National Library
of Canada

Bibliothèque nationale
du Canada

Canadian Theses Service

Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

NL-339 (r. 88/04) c

Canada

THE UNIVERSITY OF ALBERTA

IDENTIFYING AIDS EDUCATIONAL NEEDS OF METIS ADULTS

BY

LUCY C. JUDGE

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE
IN
FAMILY LIFE EDUCATION
DEPARTMENT OF FAMILY STUDIES

EDMONTON, ALBERTA
(SPRING/1989)

National Library of Canada
Canadian Theses Service
Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada
Service des thèses canadiennes

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-52995-4

Canada

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: Lucy C. Judge

TITLE OF THESIS: Identifying AIDS Educational Needs of Metis Adults

DEGREE: Master of Science

YEAR THIS DEGREE GRANTED: 1989

Permission is hereby granted to THE UNIVERSITY OF ALBERTA LIBRARY to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only. The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

Lucy Judge
(Student's Signature)

211 Mohr Avenue
Spruce Grove, Alberta, T7X 2J5
(Student's permanent address)

Date: April, 1989

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Identifying AIDS Educational Needs of Metis Adults submitted by Lucy C. Judge in partial fulfillment of the requirements for the degree of Master of Science in Family Life Education.

Dianne K. Kieren
Supervisor

Brenda A. Munro

Date: April 12, 1989

ABSTRACT

As the first step towards providing AIDS education for Metis adults, a comprehensive identification and assessment of AIDS educational needs was conducted for the adults living on the Elizabeth Metis Settlement in northeastern Alberta. The absence of a vaccine or cure for AIDS dictates that health education must promote the adoption of AIDS risk free behaviors. To assist in identifying the needs that should be addressed in a program designed to promote behavior change, an AIDS educational model was developed. This model used the assumptions of the Health Belief Model (Becker, 1974) to incorporate the variables viewed to be key determinants of behavioral change with respect to reducing the identified AIDS risk behaviors.

Guided by the AIDS Educational Model, the study utilized a convergent approach, in that information was gathered from several sources and analyzed using a variety of strategies, to identify and assess needs. The needs of the Metis adults with respect to health, sexuality, and AIDS attitudes as well as their educational learning preferences were identified through the use of scale items and open-ended questions in a personal interview. Then more specific feedback as to likes and dislikes regarding AIDS educational material was sought in focused group discussions following the viewing of several types of AIDS educational materials.

Data from statistical and content analyses were used to describe the needs common to all the Metis adults living on the Settlement as well as those specific to gender or age. The results suggested that the probability of the Metis adults practicing AIDS risk free behaviors would be influenced by such things as increasing the adults' access to accurate information about AIDS; making the disease more "real" to them; and increasing their comfort level regarding the discussion of sexual issues. Using a "people orientated" approach and a variety of methods were seen as ways to enhance the probability of practicing the desired behaviors. The AIDS educational needs, including learning preferences, were assessed and implications for AIDS educational programming for this population were discussed.

ACKNOWLEDGMENT

To my advisor, Dr. Dianne Kieren, I would like to extend my sincere appreciation for her continual assistance, encouragement, and support throughout the preparation of this thesis. I would also like to thank Dr. Anne Neufeld and Dr. Brenda Munro not only for serving on my committee but also for their constructive advice.

Special thanks go to the residents and administrative staff of the Elizabeth Settlement, who gave their time and cooperation to participate in the study.

Thanks are also extended to the staff at the Northeastern Alberta Health Unit for their invaluable assistance throughout the study. Their interest and willingness to help was greatly appreciated.

In addition, thanks are sincerely offered to those who provided special assistance along the way: Rita Bell, Dr. Graham Clarkson, Wendy Cobham, Laura Collins, and my fellow students. I would also like to thank the B.C. Centre for Disease Control and Medical Services, Health and Welfare Canada for providing audiovisual materials used in the study as well as to the Edmonton Board of Health and Dr. Robert Young for permission to use their research instruments.

The research reported here was supported by a grant from Alberta Community and Occupational Health (presently called the Alberta Department of Health).

Finally, I would like to express gratitude to my family and friends.

TABLE OF CONTENTS

CHAPTER PAGE

1 STATEMENT OF THE PROBLEM 1

Current Educational Efforts 1

Impact of Race and Ethnicity on Adult Needs 2

Impact of Age on Adult Needs 4

Research Questions 5

Objectives 6

Definitions 7

2 CONCEPTUAL FRAMEWORK 8

Health Education and Promotion 8

AIDS Educational Model 8

Summary 13

3 LITERATURE REVIEW 14

General Review of AIDS 14

AIDS Education for Adults 16
    Target Group 16
    Education Format and Efforts 17
    Summary 19

Health Education for the Metis 20
    Metis Health Beliefs 20
    AIDS Education for the Metis 24
    Summary 27

4 METHODOLOGY 26

Research Design 26
    Educational Need Identification and Assessment 26
Research Procedure 28
    Description of the Sample 28
    Permission 30

Data Collection 31
The Interview 32
Viewing and Discussion of AIDS Educational Materials 37
Data Analysis 38

5 NEED IDENTIFICATION 40

AIDS Concerns 40
Summary 42

Individual Perceptions 43

AIDS Attitudes 43
AIDS Attitude Scale 44
Fear of AIDS 47
Perceptions of the Disease........ 48
Summary 50

Modifiers 51

Personal Characteristics 51

Attitudes toward Health 53
Health Attitude Scale 53
Meaning of Health 54
Ways of Keeping Healthy 55
Traditional Medicine 56
The Church's Influence on Health 58
Making Health Behavior Changes 60
Community Needs regarding Health 60
Summary 61

Attitudes toward Sexuality 63
Sexuality Attitude Scale 63
Comfort with Discussing the Topic of Sex 67
Learning about Sex 68
Sources of Sexual Information 70
Homosexuality 71
Summary 72

Knowledge of AIDS 74
Summary 76

Stimulus to Act 76

Contact with AIDS 76

Direct and Indirect Educational Sources 77
Indirect Sources of AIDS Information 78
Direct Sources of AIDS Information 80

Preferred Learning Strategies 80
Methods 81
Techniques 89

Summary 95

6 NEED ASSESSMENT 97

Perceptions of AIDS 99

Health Attitudes 103

Sexuality Attitudes 105

Knowledge of AIDS 106

Personal Characteristics 109

Stimulus to ACT 111
Contact with AIDS 111
Indirect Educational Sources 112
Direct Educational Sources 113

Summary 114

7 IMPLICATIONS, LIMITATIONS, and RECOMMENDATIONS 116

Program Planning Implications 116

Limitations of the Study 117

Recommendations for Future Research 118

REFERENCES 119

APPENDIX A Instruments 124

APPENDIX B Metis and University of Alberta Comparison Tables 140

APPENDIX C Percentage Analysis of the Metis Adults' Responses to Individual Items on the Attitude Scales 143

APPENDIX D Correspondence related to Research 154

LIST OF TABLES

Table	Description	Page
4.2	Adult Participation by Gender and Age Category	29
5.1	Mean Scores for the AIDS Attitude Scale as a Function of Gender and Age Category	44
5.2	Two-way Analysis of Variance by Gender and Age Category for the AIDS Attitude Scale	45
5.3	Two-way Analysis of Variance by Gender and Age Category for the Lack of Action Subscale	46
5.4	Mean Scores for the Fear of AIDS Scales as a Function of Gender and Age Category	47
5.5	Personal Characteristics of Participants	52
5.6	Mean Scores for the Health Attitude Scale as a Function of Gender and Age Category	53
5.7	Mean Scores for the Sexuality Attitude Scale as a Function of Gender and Age Category	64
5.8	Two-way Analysis of Variance by Gender and Age Category for the Sexuality Attitude Scale	64
5.9	Two-way Analysis of Variance by Gender and Age Category for the Responsibility for Prevention Subscale	65
5.10	Two-way Analysis of Variance by Gender and Age Category for the Sexual Privacy Subscale	66
5.11	Two-way Analysis of Variance by Gender and Age Category for the Behavioral Responsibility Subscale	66
5.12	Knowledge of AIDS	75
5.13	Reported Direct and Indirect AIDS Educational Sources	77
5.14	Reported Ways of Informing the Settlement Members about Health Risks	82
5.15	Reported Preference of Educational Method by Gender and Age Category	83

LIST OF FIGURES

Figure Page

2.1 AIDS Educational Model 11

4.1 Need Identification and Assessment Process 27

CHAPTER 1

STATEMENT OF THE PROBLEM

The discovery of the Human Immunodeficiency Virus (HIV) which causes AIDS, and the resulting increasing numbers of people of all ages being diagnosed as carrying this virus, has precipitated the development of AIDS educational programs by many government departments and private organizations. Prevention, of which education plays a major role, is presently the only way to combat this incurable and often fatal disease. Therefore, ensuring the effectiveness of educational programs is vital if the spread of this disease is to be stopped.

Current Educational Efforts

A great deal of time and energy is being spent on developing AIDS educational programs for high-risk groups such as homosexuals, bisexuals, and intravenous drug users (Griggs, 1987; Newman, 1987). Special programs for adolescents are also being developed to respond to their increased risk of exposure. The adolescent's risk is believed to result from a number of factors: their developmental stage, which includes curiosity about sex and drugs; their idealistic attitudes; and the long term implications of habits developed in youth (Center for Population Options, 1987). In contrast, the general adult population has had less AIDS educational programming focussed towards them. Efforts to inform this group have used mainly the media and print resources. This approach has resulted in an increased awareness of AIDS, but may have unintentionally contributed to further confusion, anxiety, and fear about the disease (Alberta Community and Occupational Health, 1988). Calls received by AIDS hot lines inquiring about such things as how the disease is transmitted, how one can determine personal risk, and identifying methods of protection, illustrate some of the needs of adults; but how complete a picture of adult needs has this presented? Are these the primary needs that have to be met for adults to practice AIDS risk free behaviors? In order to develop educational strategies to facilitate the practice of AIDS risk free behaviors, educators must first comprehensively identify what the adult learner's needs are with respect to AIDS and AIDS prevention.

Impact of Race and Ethnicity on Adult Needs

Most educators would agree that there are certain general or generic needs which all adults have with respect to AIDS. In addition, it is possible for subgroups of adults to have specific needs. For example, it has been shown that knowledge of AIDS and misconceptions about the transmission of HIV differs with race and ethnic background (DiClemente & Boyer, 1987). These differences have significance when developing AIDS education programs for the people of Canada. Multiculturalism is a fact of life in Canada. Not only do we have an increasing number of immigrants from the Third World, but over the years many other ethnic groups such as Ukrainian, European, and Japanese have settled in Canada. In addition there are the Native (Aboriginal) cultural groups which includes status Indians, Inuit, and Metis. Although some people may feel that it is discriminatory to identify Native (Aboriginal) people as having unique needs, perhaps we are doing them a disservice and putting them at greater risk if we don't focus directly on their particular uniqueness. Judge Rosalie Abella said, "Sometimes equality means treating people the same, despite their differences, and sometimes it means treating them as equals, by accommodating their differences" (1984).

The Metis people, in particular, are a group that have often been overlooked as having a distinct culture and thus distinct needs. This may have occurred for several reasons. Primarily their needs have been assumed to be the same as those of status Indians. This assumption may not be valid as the Metis culture is a blend of Native and White cultures. Culture plays a significant role in AIDS prevention as it determines the socially learned characteristics of response that govern to a considerable extent what cues individuals heed, what meaning they give to them, and which consequences matter (Taba, 1962). Thus, if educational programs are to be effective in influencing the individual to practice particular behaviors, cultural components that affect these behaviors must be addressed.

Certain health behaviors have been identified as contributing to the prevention of AIDS. These health behaviors are influenced by numerous factors. Many health educators have used the Health Belief Model (Becker, 1974; Becker, Drachman, & Kirscht, 1974; Green, Kreuter, Deeds, & Partridge, 1980; Kegeles, 1963) to argue that beliefs, attitudes, perceptions, and knowledge are among the predisposing factors that can be used to predict an individual's behavior. The literature suggests further that members of particular social and ethnic groups may differ in their perceptions of certain episodes of illness and disease.

In a study of three racial groups concerning the community beliefs and feelings about tuberculosis, Jenkins (1966) identified that the collective experience of the group had a powerful effect on shaping the individual's beliefs and feelings. More specifically, a study (DiClemente & Boyer, 1987) of 1326 high school students in San Francisco, identified that there were racial and ethnic differences in knowledge of AIDS and misconceptions about the transmission of HIV. This research concluded that these misconceptions may have resulted from inadequate education targeted to these ethnic groups. It also indicated that future AIDS education designed to counter and correct these misconceptions, must provide factual information about the disease and sensitivity to the cultural and emotional issues created by this epidemic.

Impact of Age on Adult Needs

AIDS education programs for high risk groups have, to varying extents, been designed to address the specific needs of the intended target population. However, there has been little evidence of addressing specific needs when providing AIDS information to the adult population. AIDS education for adults has been targeted to a general audience and, on the whole, does not consider specific needs of different cultural or ethnic groups. Although the general adult population is not seen as a high risk group, the recognition of AIDS as a threat to heterosexuals (Cardell, Kanouse, Gorman, Serrato, Reuter, & Williams, 1987; DeGruttola & Mayer, 1987; Steigbigel, Maude, Feiner, Harris, Saltzman, & Klein, 1987) supports the view that the general adult population does need specifically designed AIDS education. Further, it could be argued that adults require AIDS education not only to protect their own health, but also to carry out their key roles in the socialization of youth, and to influence the formation and implementation of public policy in society.

With regards to AIDS educational needs, Metis adults can be divided into three groups: young adults, parents of adolescents, and older adults. The young adult group, despite the fact that AIDS crosses all age barriers, is particularly important to reach with information about AIDS since members of this group are at the age of experimentation with both sex and drugs. Many of these young adults have not had the opportunity for formal AIDS education due to dropping out of school or having attended school before AIDS education programs were offered. During adolescence, the influence of peers, often through modeling, plays an important role in decision making especially in sexual behaviors (Biddle, Bank, & Marlin, 1980; Billy & Udry, 1985; Brown, Classen, & Eicher, 1986; Woodroof, 1986). This creates the need for all adolescents, both those attending school and those who are not, to obtain factual information about AIDS and

AIDS prevention so that decisions affecting their well-being can be made based on accurate information regarding possible risks.

The second group, parents of adolescents, are identified as being in the position of reinforcing and interpreting, according to their beliefs, what the adolescents have learned in school about AIDS and AIDS prevention. While parents provide modeling for their adolescents, they also tend to influence them through setting norms (Biddle, Bank, Marlin,1980). Parents often do not have the knowledge or comfort level to teach or discuss the issues involved in AIDS prevention with their adolescents (Centre for Population Options, 1987; Leo,1986).

The remaining group of older adults, along with the parents of adolescents, are in the position to shape the environment through their involvement in community decision and policy making. In addition, the older adults may influence the resources available to prevent the spread of AIDS (e.g., access to information, condoms, etc.) as well as help to incorporate AIDS risk free behaviors into their cultural beliefs.

Thus, to prevent the spread of AIDS in Metis communities, AIDS education programs that address the unique needs of this cultural group must be provided. For this education to be effective, these needs should reflect the present cultural environment as well as the knowledge, attitudes, beliefs, and behaviors of the Metis people.

Research Questions

This study undertook to identify the unique needs of a group of Metis adults with regards to AIDS education. The research questions that guided the study were:

1. What are the needs of a group of Metis adults regarding health education about AIDS and AIDS prevention?
2. How do the needs among this group of Metis adults differ by gender and/or age category?

3. How do the needs of this group of Metis adults compare with those of other adults?

Objectives

The following objectives develop more specifically the study's focus:

1. To identify the present knowledge and beliefs of Metis adults (18 years and older) about health issues related to AIDS and AIDS prevention.
    - i. To identify their present beliefs about health.
    - ii. To identify their present beliefs about sexuality.
    - iii. To identify their present knowledge and beliefs about AIDS and AIDS prevention.
2. To contrast:
    - i. the needs regarding AIDS and AIDS prevention by gender and age categories within a Metis adult population.
    - ii. the needs regarding AIDS and AIDS prevention of a Metis adult population with those of parallel general adult populations as described in the literature .
    - iii. the needs of a group of Metis adults with those of another group of adults regarding beliefs surrounding the health issues involved in AIDS and AIDS prevention, and knowledge of AIDS.
3. To identify the educational learning strategies preferred by a group of Metis adults regarding AIDS and AIDS prevention education.
4. To develop recommendations for future health education in AIDS and AIDS prevention for this population utilizing the identified needs.

Definitions

Attitudes - A set of beliefs directed toward an object, person, or situation in which there is an evaluative component.

Beliefs - A statement or sense, declared or implied, intellectual and/or emotionally accepted as true by a person or group.

Knowledge - The awareness of facts and some understanding of how these relate to one another or to outside entities.

Health Education - A dynamic process that uses a combination of methods to facilitate voluntary adaptations of behavior conducive to health.

Learning Strategies - The methods and techniques of educational learning.

Metis - an individual of aboriginal ancestry who identifies with Metis history and culture.

Native (Aboriginal) - A group of persons which includes status Indians, Inuit, and Metis (Canada's Constitution Act, 1982).

Need - a gap between what is now and what would be desirable, in terms of proficiency and performance (Price, 1982).

CHAPTER 2

CONCEPTUAL FRAMEWORK

Health Education and Promotion

The aim of all health education and its broader concept, health promotion, is to have a positive impact on health, not only in an effort to prevent illness, but to positively improve the quality of health and thus the quality of life (Breckon, Harvey, & Lancaster, 1985; Dignan & Carr, 1987; Epp, 1986; Ewles & Simnett, 1985; Green, Kreuter, Deeds, & Partridge, 1980; Somers, 1976; World Health Organization,1986). The concept of health promotion as " the process of enabling people to increase control over, and to improve, their health" (World Health Organization, 1986) includes providing information through traditional health education, as well as other methods such as marketing and advertising (Dignan & Carr, 1987; Ewles & Simnett, 1985). The obvious first step in either health promotion or education is to identify and assess the health concerns and needs as these not only indicate if some action should be taken, but also help in setting priorities and making decisions about the type of action and its possible outcomes (Green, Kreuter, Deeds, & Partridge, 1980; Harmon, 1976; Kamis, 1979; Kaufman & English,1979; Witkin, 1984). In this research, need identification will be defined as describing, for a particular group in a geographic area, the components that influence the individual's behavior and behavior changes with regards to health. Need assessment, on the other hand, is the estimation of the relative importance of these needs (adapted from Siegel, Attkisson, & Carson, 1978).

AIDS Educational Model

Because the development of AIDS health education is in its infancy, this research will focus on identifying the learner need components for a specific target population, the Metis adults. In order to place the identification of learner needs in context, an AIDS

Education Model has been developed and will comprise the conceptual framework for the present research. Health education in this conceptualization is a dynamic process which involves not only the process by which knowledge is obtained, but also the process by which values and attitudes are explored, decisions are made and action is taken.

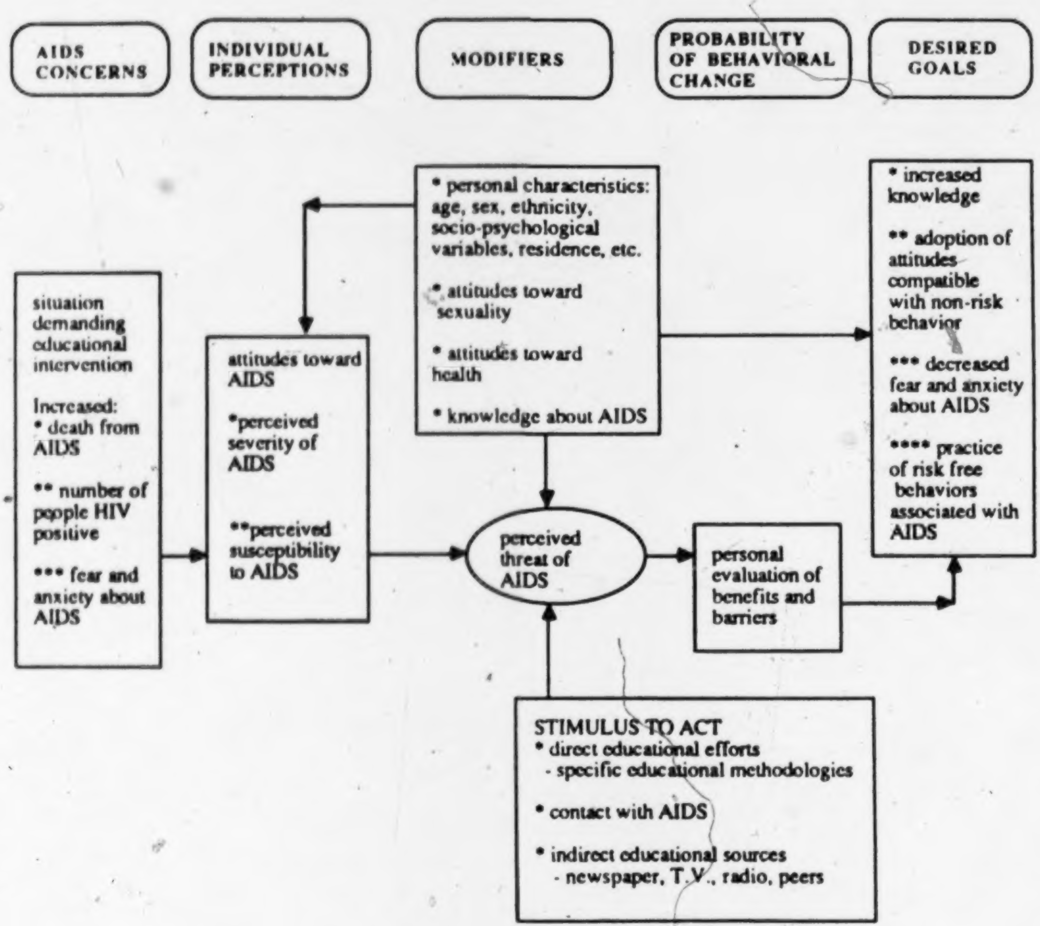
The AIDS Educational Model (Figure 2.1) was developed using information from research on the transmission of AIDS and other sexually transmitted diseases, and theories involving factors that impact health behavior. The model begins with a concern, either societal or individual, that people are suffering increased fear and anxiety due to the existence of AIDS, as well as, the increased risk of contracting HIV or dying of AIDS. These concerns result in the need for health education to promote behaviors that will strive to resolve the problem. Once the concern is noted, the health education process has begun.

The next step is to identify and assess the needs of a specific learner population with regards to the the noted concern. There are many ways to identify what is needed to move from the concern to the desired goals. This framework utilizes the Health Belief Model (Becker, 1974) to incorporate the variables viewed to be key determinants of behavioral change with respect to reducing the identified AIDS risk behaviors. These key variables are: a person's perception of the seriousness and the threat of the disease, readiness of the person to take action (based upon a balance of benefits and barriers to action), and the impact of behavioral change interventions which are designed to encourage a person to take action.

The Health Belief Model is based on the assumption that an individual's perceptions of need and the factors that influence these perceptions are the determinants of behavior. The components that comprise the Health Belief Model are: (1) the readiness of the individual to consider behavioral changes to minimize or avoid health risks, (2) the existence and influence of forces in the individual's environment that urge change and make it possible, and (3) the behaviors themselves. In addition, these factors are also influenced by the personality and the environment of the individual.

FIGURE 2.1

AIDS EDUCATIONAL MODEL


AIDS CONCERNS
INDIVIDUAL PERCEPTIONS
MODIFIERS
PROBABILITY OF BEHAVIORAL CHANGE
DESIRED GOALS
situation demanding educational intervention
Increased:
* death from AIDS
** number of people HIV positive
*** fear and anxiety about AIDS
attitudes toward AIDS
*perceived severity of AIDS
**perceived susceptibility to AIDS
* personal characteristics: age, sex, ethnicity, socio-psychological variables, residence, etc.
* attitudes toward sexuality
* attitudes toward health
* knowledge about AIDS
perceived threat of AIDS
personal evaluation of benefits and barriers
* increased knowledge
** adoption of attitudes compatible with non-risk behavior
*** decreased fear and anxiety about AIDS
**** practice of risk free behaviors associated with AIDS
STIMULUS TO ACT
* direct educational efforts
- specific educational methodologies
* contact with AIDS
* indirect educational sources
- newspaper, T.V., radio, peers

Based on these components, the AIDS Educational Model identifies the factors that affect the movement between the concern about AIDS and the desired goals. INDIVIDUAL PERCEPTIONS in this model refer to the individual's attitudes toward AIDS and more specifically the individual's perceived susceptibility to the disease and the perceived severity of AIDS. These perceptions in turn influence how the individual perceives the threat of AIDS. Personal characteristics such as age, sex, and ethnicity, as well as some general attitudes (health and sexuality) and knowledge of AIDS, act as MODIFIERS, not only modifying the individual's attitudes toward the disease, but also directly influencing the perceived threat to the disease and the attainment of the desired goals. In addition, the perceived threat of AIDS is modified by factors under the heading--STIMULUS TO ACT. This component includes direct educational efforts, indirect information sources and contact with the disease. The PROBABILITY OF BEHAVIORAL CHANGE is seen as the result of the individual's evaluation of the benefits and barriers to practicing risk free behaviors associated with AIDS.

The AIDS Educational Model illustrates the complexity of an educator's task in working to attain the desired goals of an education intervention. It suggests that a need identification and assessment for a target group must focus on more than knowledge gaps. Furthermore, the fact that the specific target audience consists of adults also demands considering more than lack of knowledge. As adults will only participate insofar as they perceive the program content and approach to be addressing their needs (Harmon, 1976), it is important to identify what they want to learn about AIDS and how they would like to receive this information, that is what educational methods and techniques they prefer.

A factor that influences all the model components, but may not stand out prominently is culture. According to Harmon " each and every community of people exist within a cultural and environmental context from which it derives a unique and dynamic character, requiring that the understanding of groups be based on their analysis within the confines of those contexts, and that the planning and development of activities be anchored in such situation specific analysis" (1976, p.31). This statement demonstrates the importance of not assuming that educational needs are generic and promotes the identification of not only specific needs of different cultural groups, for example the Metis, but also specific needs within a cultural group.

The influence of culture is both subtle and powerful. Each time individuals receive health information, this information is filtered through their knowledge, attitudes, beliefs, values, and skills (or lack of skills) before any response behavior is exhibited (Greene & Simons-Morton, 1984). Not only do knowledge, attitudes, beliefs, values, and skills interact with each other, but each of these is also being influenced by the culture within which the individuals live. In addition, culture is not stagnant, but reflects to some extent societal changes. This constant interaction both within the individual, and between the individual and his world, results in the health education process having to continually adapt to the current needs of the specified learners.

Summary

Education, particularly voluntary adult education, must meet the needs of the learner. Therefore, relevant and functional health education programs must be based on the assessment of identified factors that comprise the learner's need. The AIDS Educational Model indicates the key variables that should be identified and assessed in order to determine whether an individual will practice AIDS risk free behaviors and how an educator can enhance this probability. While these factors are constantly interacting, they are at the same time, being influenced both separately and collectively by the individual's culture and society as a whole. To respond effectively to the constantly changing demands, expectations and stimuli surrounding the issue of AIDS, health education must be both dynamic and ongoing.

CHAPTER 3

LITERATURE REVIEW

The present knowledge about AIDS has resulted in the undertaking of certain activities, as well as indicating future actions that should be taken, in order to prevent further spread of the disease. A review of the literature relevant to this research will include a brief general review of the disease AIDS and an overview of AIDS education for adults. As well, the literature addressing the presently identified health education needs of Metis adults, and more specifically needs in relation to AIDS education, will be discussed.

General Review of AIDS

The literature clearly indicates that the scientific knowledge about AIDS is not comprehensive. Although neither a cure nor a vaccine to prevent AIDS has been discovered, the medical community does agree on the general disease process. AIDS, which stands for Acquired Immunodeficiency Syndrome, is a disease caused by the Human Immunodeficiency Virus (HIV). This virus attacks the body's immune system leaving the individual susceptible to many infections and cancers. HIV is found in bodily fluids, such as blood, semen or vaginal fluid, of an infected person and is spread when any one of these fluids enters the bloodstream of another person. There are three known routes of transmission. First is penetrative sexual intercourse with an infected person where partners may be two men or a man and a women. The second route is inoculation with infected blood through the use of contaminated needles or syringes for such activities as the abuse of intravenous drugs, tattooing, or acupuncture; or through the transfusion of contaminated blood or blood products. In Canada, the latter method is rare since November 1985 when the Canadian Red Cross started testing all donated blood for HIV. The third way the virus is transmitted is from an infected mother to her baby before or during birth, or possibly after birth through breast-feeding. Although small amounts of the virus have been identified in tears and saliva, the concentration appears to be insufficient to cause an infection. Not everyone who becomes infected with HIV develops AIDS but all infected people, whether they show disease symptoms or not, can spread the virus if they engage in behaviors where bodily fluids are exchanged (Greig, 1987).

The lack of success in discovering a cure for AIDS or a vaccine to protect people from developing the disease has left only one alternative - to prevent people from exposing themselves or others to the virus, or to prevent infection during activities the can transmit HIV (Alberta Community and Occupational Health, 1987; Francis & Chin, 1987, Gilmore, 1988; Greig, 1987; Kapila, 1988). As the majority of HIV transmission is the result of consensual behavior, that is, sexual intercourse and the use of contaminated needles, education about the behaviors associated with the transmission of HIV becomes crucial.

Providing facts about the disease process may not be sufficient to reduce the spread of AIDS (Solomon & DeJong, 1986; Williams, 1986). At the moment, preventing the further spread of AIDS appears to depend on health education to facilitate voluntary changes of behavior conducive to having the ability to adapt continually to the constantly changing demands, expectations, and stimuli surrounding the issue of AIDS (Ewles & Simnett, 1985; Green, Kreuter, Deeds, & Partridge, 1980; Kleinschmidt & Zimand, 1953). Health education to be effective must, not only, increase the individual's knowledge about AIDS, but also address such things as the individual's perceived risk of AIDS and perceived efficacy of behavioral changes for reducing the chance of developing AIDS (Emmons, Joseph, Kessler, Wortman, Montgomery, & Ostrow, 1986). In addition, the changes necessary to control the spread of AIDS are not just a one time behavior change, for example, getting tested for HIV antibodies, but are behavior changes that must be maintained until a cure or vaccine is found.

AIDS Education for Adults

Target Group

AIDS education was initially directed towards groups in which high risk behaviors were found, that is, homosexuals/bisexuals and IV drug abusers (Williams,1986). Programs then expanded to address the needs of adolescents who were believed to be at risk due to their developmental stage which involves curiosity and experimentation; their somewhat egocentric, present-time orientation; and their sense of personal invulnerability. Recent acknowledgment that AIDS is spreading more and more through heterosexual contact (Cardell, Kanouse, Gorman, Serrato, Reuter, & Williams, 1987; DeGruttola & Mayer, 1987; Steigbigel, Maude, Feiner, Harris, Saltzman, & Klein, 1987), led to the adult population being included as a target group in the AIDS educational campaign. Adults need health education not only to protect their own health, but also because they influence the behavior of children and adolescents through modeling and support (Perry, Crockett, & Pirie, 1987). Furthermore, adults require knowledge about AIDS as they are influential in shaping the environment through decision and policy making.

Recent studies (Edmonton Board of Health, 1987; Slavin & Smith, 1987) have shown that adults do indeed desire more information about AIDS. A telephone survey (Alberta Community and Occupational Health, 1988) of a stratified random sample of 1,000 adult Albertans from throughout the province, reported that almost all adult Albertans surveyed (96%) felt it was very necessary to inform the general public about AIDS, how it is spread, and methods of prevention.

Education Format and Effects

Most of the information that is reaching the adult population has been through the media. Newspapers hardly miss a day without printing an article about AIDS. Television and radio stations are running both commercials (Canadian Public Health Association, 1987) and special programs on the subject . Several studies (Alberta Occupational and Community Health, 1988; Edmonton Board of Health, 1987; Hastings & Scott, 1987; Mason, Noble, Lindsey, Kolbe, Van Ness, Bowen, Drotman, & Rosenberg, 1988; Slavin & Smith, 1987) indicated that the mass media coverage had been successful in communicating some information about AIDS, however significant myths, misunderstandings, confusion, and fears continued to persist.

Another means of reaching the the adult population has been through printed material such as books (e.g. AIDS: What Every Responsible Canadian Should Know, Greig, 1987; Safe Sex, Scotti & Moore, 1987; and David Suzuki Talks about AIDS, Suzuki, 1987) and pamphlets (e.g., AIDS in Canada: What You Should Know,1985; Making Sex Safer,1987; and AIDS: The New Facts of Life, 1988). All levels of government health departments - federal, provincial and municipal - have produced information pamphlets in an effort to provide the adult population with accurate information. In addition, many AIDS organizations such as AIDS Network, Edmonton and private industries such as Ortho are also distributing information brochures. With such a volume of literature it is not surprising that adults become confused about the facts. Furthermore, written material, to be a useful source of information, must be accessible to the reader as well as in a language and reading level that the reader can comprehend. Although some pamphlets have been translated into the native languages of the Northwest Territories, the majority of Canadians have only the choice of receiving AIDS information in English or French.

The desired effect of AIDS health education is to promote behavior change in adults that reduces their risk of contracting HIV which may lead to AIDS and possibly death, and to lessen their fear and anxiety about the disease. While statistics on the number of diagnosed AIDS cases and HIV carriers will give some indication of AIDS health education effectiveness, they will probably not be available for a number of years and must be interpreted with caution. In the first place, the symptoms which indicate a diagnosis of AIDS may not appear for five to ten years after the individual becomes infected with the virus. Secondly, as HIV testing is not mandatory, there is no way to get an accurate number of people who are infected with the virus.

An alternative method of determining the effectiveness of AIDS education is to ask adults if they have changed their behavior since the discovery of AIDS. Very few surveys have been done in this area, as asking adults about their behaviors that relate to AIDS and AIDS prevention, especially regarding the sexual issues involved, is often seen as too intrusive. A survey done for Alberta Occupational and Community Health (1988) did ask adults their degree of agreement (strongly agreed, agreed, undecided, disagreed, or strongly disagreed) with a statement that the threat of AIDS had caused them to change their sexual habits. One in four Albertan adults surveyed agreed, with the level of agreement increasing as greater levels of fear about themselves or someone close to them getting AIDS was expressed. Higher levels of agreement were seen in single adults and the younger adults. The survey did not discover the reason for seventy-five percent of the Albertan adults indicating that they had not changed their sexual behaviors. Two possible reasons could be given. One, these adults were not involved in behaviors that would put them at risk for contracting HIV or two, these adults were not aware of the seriousness of the problem and how it might relate to their behaviors.

Educational programs related to AIDS are relatively recent, and thus there are few summative evaluations available to provide guidance in developing additional AIDS education programs. Some related literature on sexually transmitted diseases may offer some guides for AIDS education. Research by Solomon & DeJong (1986) studied whether education efforts could successfully motivate the adoption of key behaviors relevant to the control of sexually transmitted diseases. It was found that prevention materials, to have credibility, had to acknowledge the beliefs and values of the target population. Furthermore, the effectiveness of the materials depended upon providing appropriate levels of information in a language and graphic style appealing to and suitable for the intended audience. Motivation to change behavior was linked with the audience identifying, in the prevention materials, with people similar to themselves adopting the desired behavior. Being able to identify oneself with the desired behavior through the use of materials that not only reflect the target group's needs and desires but is encompassed in language, images and strategies to which the group can relate, resulted in positive behavioral, attitudinal, and cognitive outcomes.

Of the few AIDS information programs specifically addressing the needs of the adult, these are usually directed towards adults who are at high risk of contracting AIDS. The Detroit Health Department health education staff (Williams,1986), when developing an AIDS community education intervention for the high risk groups of homosexual/bisexual men and intravenous drug users, identified a lack of sufficient data on the health beliefs, attitudes, and prevention practices of minorities necessary to design relevant risk education activities. They found the traditional methods of health education planning were inadequate and developed a strategy where members of the high-risk population were encouraged to assume leadership roles in the development and implementation of the program.

Summary

Until a cure or vaccine is found for AIDS, health education must promote the adoption of behaviors that reduce the individual's risk of being exposed to the disease.

Although the general adult population is not seen as a high risk group, the increasing spread of AIDS in the heterosexual population has warranted more health education being targeted towards them. The mass media approach used to inform the public about AIDS, while increasing their awareness about the disease, has left some adults confused about the risk associated with certain behaviors. In addition, there appears to have been little behavior change as a result of being made aware of the disease. Therefore, health education designed to actively promote behavior change must be developed and implemented. Research suggests that the key to effective health education programs is to present the right message to the right audience in the right way (Sarner, 1984). Thus the first step in AIDS education is to identify the right AIDS message and the right way to educate a specific audience about the disease.

Health Education for the Metis

A review of the literature revealed a lack of health education programs directed specifically towards the Metis population. Metis people are either offered programs designed for the general public or sometimes those designed for "Natives" where status Indians, non-status Indians, and Metis have been assumed to the same or similar educational needs. Therefore, the first step in developing AIDS health education for Metis adults would be to identify the present Metis health beliefs that predict the health behaviors that are involved in AIDS prevention (Becker, 1974; Dignan & Carr, 1987; Ewles & Simnett, 1985; Green, Kreuter, Deeds, & Partridge, 1980; Greene & Simons-Morton, 1984).

Metis Health Beliefs

The bulk of the available literature about the Metis tends to focus on their historical and cultural background with very little mention of matters concerning health. As the name Metis indicates, the mixing of blood has resulted in a group of people who have a variety of beliefs depending on their particular situation. Some Metis integrated into

White society, others became incorporated into the Indian reservations; but most remained separate, living on the fringes of either White society or an Indian reservation, and in Alberta after 1938, had the opportunity to live on Metis settlements (Douaud, 1983). Comments from two groups of Metis illustrate some of the resulting differences in beliefs.

The Metis living on the Elizabeth Metis settlement in Alberta were reported in a local history book as feeling they have developed their own culture that is distinct from both the Native and the White (Elizabeth Metis Settlement Association Council, 1979). The Red River jig is seen as one of the unique aspects of Metis culture on the Elizabeth Settlement. In contrast, a group of Metis women in Northern Saskatchewan reported seeing themselves as still having as part of their culture the "Indian way" which consists of "Indianness", native language, and certain customs and traditions (Poelzer & Poelzer, 1986). Customs and traditions include not only the traditional occupations of hunting, fishing and trapping and the traditional skills such as "living in the bush" and making moccasins, but also certain values and norms dealing with relationships and attitudes towards others. They have a strong sense of family, which is seen in the deep care, concern and loyalty they have to their kin. There is also a tradition of sharing and generosity, of responding to those in need and of relating to others.

Poelzer & Poelzer's work included a discussion about reproductive health education. These Northern Saskatchewan Metis women felt that children should have reproductive health education as it was necessary not only for better adaptation to physical and psychological changes at the time of puberty or pregnancy, but also such information was necessary in order to acquire a healthy attitude towards "sex". Many of these women had not been taught very much about this subject as a child. The majority favored teaching reproductive health information in the schools, but some thought sex was something "sacred-like" and should be provided at home.

As already mentioned, many Metis have retained some aspects of Indian culture. This has resulted in some of the Metis adults, particularly the older ones, continuing the use of folk medicine (Tarasoff, 1980). Often people will seek help from a medicine man or woman only after the medical doctor has failed to cure some illness such as a persistent pain or cancer (Tarasoff, 1980; personal discussion with the community health representative from Fishing Lake Metis Settlement). Folk medicine is considered to be a sacred transaction involving prayers, the smoking of the pipe, a gift exchange, and perhaps the singing of a ritual song with the accompaniment of a medicine drum. Medicine Men are highly respected for their knowledge of herbs and roots, which when combined with spiritual beliefs, have been known to cure some people (Anderson, 1977).

One part of the culture that seems to be mentioned in most literature about the Metis is the tradition that grandparents teach their grandchildren about the values and ways of the Metis people (Cardinal & Ripley, 1988). Often this is done through story-telling. Elders hand down to the children such cultural beliefs as the value of the act of sharing, the respect for nature, and the importance of the extended family.

Literature also shows that within most Metis settlements, the Roman Catholic Church played an important role in providing both education and health care to the early settlers (Cardinal & Ripley, 1988; Elizabeth Metis Settlement Association Council, 1979; MacEwan, 1981; Sealey & Lussier, 1975). In many Metis communities the Church continues to play a prominent role in the spiritual welfare of the people (Elizabeth Metis Settlement Association Council, 1979).

Although the Metis have retained their sense of identity through the years, they have experienced varying degrees of cultural transition. Thus, even if Metis health beliefs had been described in the literature, there is no way of knowing whether these beliefs are still held today. Acculturation is taking place continually at different rates and in different ways. The outside influences of schools, TV, and radio have encouraged the use of

English rather than their native language in many Metis communities. The people now have greater access to travel outside their settlements and in many cases must travel off their settlements to buy groceries and other goods. People can no longer survive by hunting and fishing and must look for employment. Often employment can not be found on the settlement and if the individual chooses not to leave, there is no other choice but to live on social assistance. All these changes, and others not mentioned, can have an effect on Metis health beliefs.

While identifying health beliefs may be difficult, a health education program designed in Toronto for diabetic Plains Cree adults illustrates the importance of identifying the present cultural beliefs of the program's target group (Buller & Hagey, 1982). This program was based on the assumption that the main problem facing the Indians was not diabetes, but the negative attitudes and avoidance behaviors that prevented people from taking the time to learn to control their disease. Even though these adults were living in a large city, it was apparent after doing the study that they had retained many aspects of their traditional beliefs. A model for cross-cultural education was utilized to identify beliefs regarding the target group's principles of communication, social organization patterns, and preferences of teaching styles. Results demonstrated that present communication beliefs involved such aspects as the appropriate use of humor, body language, cultural metaphors, and the target group's dislike of direct, factual or personal questions. It also identified the group's deep rooted ideal of noninterference and the rituals that would assist in participants' learning. This study clearly indicated that successful programs must address some of these culture related issues.

AIDS Education for the Metis

The literature revealed no AIDS education programs designed specifically for the Metis, whether for adolescents or adults. There is, however, an AIDS education program for status Indians being presently piloted by Medical Services, Health and Welfare Canada on several reserves. This pilot program has adapted current AIDS educational materials for the status Indians by utilizing appropriate language and illustrative stories about Indian people. Because there was no information available on the perceived needs of status Indians regarding AIDS education or how the current health beliefs of the status Indians will influence the adoption of AIDS risk reducing behaviors, the needs addressed in this program were those that Medical Services health educators felt were appropriate.

From personal discussions with a few Metis adults, AIDS is not seen by the Metis people as the highest health priority. Instead, these Metis adults indicated the high rates of suicide among the Metis adolescents and the problem with drinking as more critical health concerns. This lack of concern about AIDS might be the result of not understanding the disease and how it is spread, or it might be the result of not having had close exposure to someone with the disease.

Summary

Although the literature does not provide a comprehensive description of Metis health beliefs, it does mention some beliefs that might affect an AIDS education program. For instance, the belief that reproductive health should be taught to children indicates, not only, that the Metis would probably approve of their children learning how AIDS is sexually transmitted, but also the possibility that the adults would be interested in learning about the disease in order to teach their children. In addition, it is important to be aware that folk medicine can play a role in maintaining health. This might warrant including a discussion of the use of folk (Indian) medicine in curing AIDS in an education program. Further, the choice of target audience might be influenced by knowing that the grandparents pass on many of the Metis traditions.

The fact that there were intra as well as inter-group differences in health beliefs among the Metis was clearly revealed literature. This suggests to develop an AIDS education program that addresses the needs of the Metis adults it will be necessary to first identify the present health beliefs of each specific target population. Educators can not assume that all Metis people, or even that all the Metis people living on one settlement, have the same health beliefs and thus the same needs.

CHAPTER 4

METHODOLOGY

This chapter contains a description of the methods used to collect and analyze data in the study. It includes a summary of the research design, procedures, and materials that were utilized to identify the nature and extent of AIDS educational needs of the target group.

Research Design

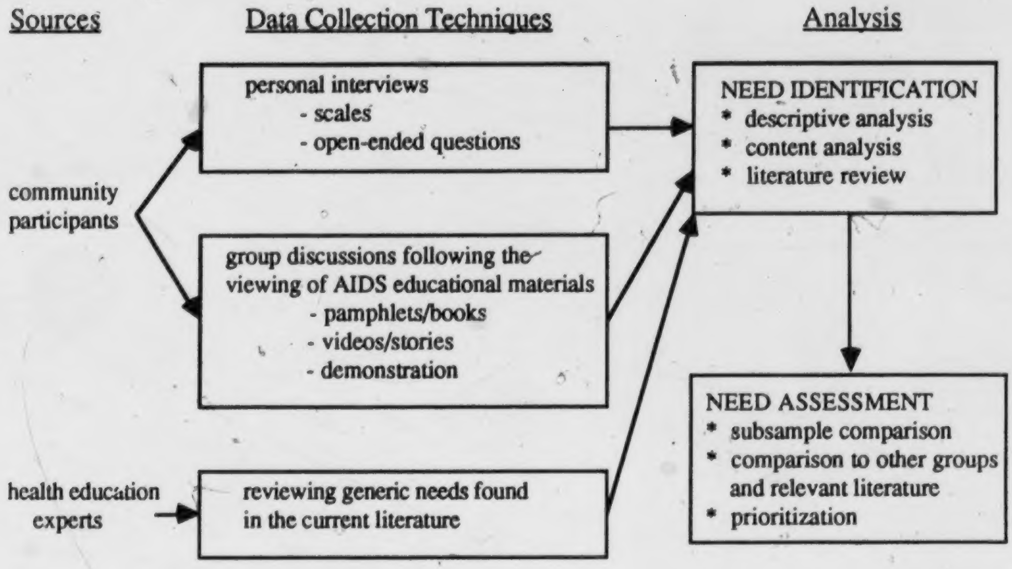
Educational Need Identification and Assessment

Specifying the educational need of a target audience is a two step process comprised of need identification and need assessment. Need identification leads to a description of need requirements for a particular group in a geographic or social area; while need assessment estimates the relative importance of these needs (Siegel, Attkisson, & Carson, 1978). There is generally no agreed upon procedure to follow which will lead one to a comprehensive identification and assessment of needs. This research used convergent analysis as the methodological framework in which information pertaining to needs could be identified, defined, evaluated, and given priority in a progressive manner (Siegel, Attkisson, & Carson, 1978). The convergent analysis involved gathering information from divergent sources, and using a variety of assessment strategies to strive for an accurate description of need.

This research undertook a survey of the the AIDS educational needs of the target population by gathering information from two primary sources, community participants and health education experts. The process of gathering this information utilized the techniques of personal interviews, focused group discussions, and reviewing of current, relevant literature. All the information was summarized by descriptive and content analyses. Finally, the descriptions obtained by these sources were then reviewed and contrasted with comparison groups and relevant literature to allow for prioritization of needs. Figure 4.1 details this process.

Figure 4.1

Need Identification and Assessment Process



Personal interviews were chosen as the main source of data collection to accommodate: the variety of reading and writing abilities among the participants, the concern that due to cultural differences some words or questions may need to be clarified, and the debriefing of participants by providing an opportunity to answer any questions the participants may have as a result of the interview.

Research Procedure

Identifying the AIDS educational needs of the Metis Adults was initiated by a request from the North Eastern Alberta Health Unit for assistance in planning AIDS educational programs for the Metis population in their area. Following discussions with the health unit administration as well as several community health nurses and representatives, a proposal for funding was developed. After being reviewed by a University of Alberta ethics committee (Appendix D), the proposal was submitted to the Alberta Department of Community and Occupational Health (presently called the Department of Health) and subsequently approved for funding.

The health unit assisted throughout the project in numerous ways: by administering the funding, by acting as consultants, by providing office space as well as access to the health unit's AIDS educational materials, and by allowing the community health representative assigned to the settlement to work as required on the project.

The Elizabeth Metis Settlement also supported the project by helping to inform the people of the project, allowing the use of the settlement's photocopier and VCR, and providing, when needed, the assistance of summer student employees.

Description of the Sample

All participants in this study met the following criteria: (a) registered members of the Elizabeth Metis Settlement Association, (b) 18 years and over, (c) fluent in English [as the researcher was unable to conduct the interview in Cree], and (d) resident of the Elizabeth Metis Settlement No. 9. at the time of the study. These criteria resulted in eligible participants being born between 1919 and 1970. The eight members of the Elizabeth Metis Settlement born prior to 1919 were identified as either being not fluent in English (4) or no longer living on the settlement (4).

To facilitate the identification of differences in needs among the adult population, the sample was divided by gender and age. Individual and family developmental task criteria were used as rationale for selecting the following age categories: young adults (18-30 years), middle adults (31-45 years), and older adults (46+ years). Table 4.2 shows a detailed breakdown of the sample according to gender and age category for both parts of the study, the interview and the assessment of AIDS educational materials.

Table 4.2

Adult Participation by Gender and Age Category

	MALE	FEMALE	TOTAL
	% N	% N	% N
Interview			
18-30 years	14.6 (6)	30.6 (11)	22.4 (17)
31-45 years	15.4 (6)	25.8 (9)	21.4 (15)
46-69 years	33.3 (8)	26.3 (5)	30.2 (13)
total	19.2 (20)	30.5 (25)	23.7 (45)
Assessment of AIDS educational materials			
18-30 years	9.8 (4)	5.6 (2)	7.9 (6)
31-45 years	5.1 (2)	16.1 (5)*	10.0 (7)*
46-69 years	12.5 (3)*	15.8 (3)	14.0 (6)*
total	8.7 (9)*	12.2 (10)*	10.0(19)**

Note: Percentages were derived for the eligible population in the community.
* = one person in this category was not interviewed
** = two people in this category were not interviewed

The survey sample was the result of purposefully trying to represent 25% of the total eligible adults in each gender-age category. It was obtained by approaching individuals in the order that they were randomly selected from the total in each gender-age category until the quota for that category was obtained. In Table 4.2 it can be noted that several categories are over-represented. This over-representation was the result of (a) discovering, when trying to contact people, that some of the adults on the eligible participant list on which the quotas for each group were based, were no longer living on the settlement, and (b) finding out during the interview that one participant had been included in the quota for the wrong age category.

Furthermore some gender-age categories did not reach the desired 25% of the eligible population. Several factors accounted for this. The fact that the survey was conducted during the summer and early fall contributed not only to the difficulty in finding people but meant that in the process of obtaining the sample, an attempt had been made to contact most of the adults in the community. Also the timing of the survey appeared to affect the poor turnout for the assessment of AIDS educational materials. That is, people were on holidays or too busy with late summer activities, for example, fishing, berry picking, and haying. In addition, a number of adults either directly stated they were not interested in participating (in the 18-30 year category, males-5 and females-4; in the 31-45 years age category, males-3, females-2; and in the 46+years group, males-1, females-1) or did not show up for the interview (in the 18-30 year category, males-5 and females-0; in the 31-45 years age category, males-0, females-2; and in the 46+years group, males-1, females-1). For those who gave reasons for refusing to participate it was usually due to lack of time.

Permission

First, permission to conduct the survey was obtained from the administrator and the council of the Elizabeth Metis Settlement Association (Appendix D). Next, the members of the settlement were informed of the survey through an article in the Elizabeth Settlement Newsletter. This was written by the community health representative for the settlement. Then, using existing membership lists, participants were randomly chosen until the 25% quota was obtained. Potential participants from each gender-age category were according to random selection, personally contacted, usually by phone, and asked if they were interested in sharing their ideas about the disease AIDS, including what and how they would like to learn about it. It was explained that the results of the survey were to be used by the community leaders and the health unit to plan an AIDS education program for their community. Details were given about what participation in the study involved. That is, they were told the survey had two parts, a personal interview lasting about 30-45 minutes, and a group viewing and discussion of some AIDS educational materials such as videos and pamphlets lasting about 1 1/2 hours. The two parts would be completed on separate days. If the individual was willing to participate, an interview time and place was arranged. If the individual did not show up for the interview, the researcher attempted to contact that person again as soon as possible. If contact was made, a second appointment was scheduled if the individual was still willing to participate. If no contact could be made or the individual did not appear to be interested, the next individual on the random selection list was approached.

Data Collection

As previously mentioned, the collection of data from the participants took place in two parts: the interview and the focused group discussion following the viewing of AIDS educational materials. The interview questions were reviewed for language appropriateness by several Metis adults living in Edmonton and then piloted with two adults on the Settlement. As a result of the pilot interviews, the response of true or false to the AIDS knowledge questions were changed to yes or no. The second part, the assessment of AIDS educational materials, was piloted with a group of six health unit employees working in the Bonnyville suboffice. No changes were made as a result of the pilot.

Within both parts, to maximize the data collection with as little inconvenience as possible to the participants, it was necessary to be flexible as to the procedure. For example, interviews took place in a variety of settings such as the participant's home, place of employment, and vehicle as well as in the health unit office in Elizabeth

Settlement; and for the assessment of AIDS educational materials, not all groups were composed of adults belonging to the same gender-age category.

The Interview

At the beginning of the interviews, the researcher introduced herself and reviewed the survey's purpose and the participants' role. It was mentioned that the nature of the survey topic required some questions about sex, although these would only ask for their opinions and not their behaviors. Based on this information, participants were allowed to decide who they would like present during the interview. The use of the tape recorder for the recording of data in both the interview and the group session was explained. The consent form (Appendix A) was discussed and signed. Each participant was given a copy of the consent form which included names and numbers of people whom they could contact if they had any concerns about the survey.

With two exceptions (2 males insisted on being interviewed together - so each answered the scale items on their own while the other responded orally to the open-ended questions), all questions were given and responded to orally. Occasionally participants would nod or shake their heads which resulted in the researcher having to verbalize the response so the answer would be recorded on the tape. If the researcher noted some confusion with a question, it was reworded. If the participants had a question about AIDS during the interview, they were asked to wait till the end of the interview for a response.

To describe the Metis adults' beliefs about AIDS, sexuality and health, as well as, how they prefer to learn about health concerns, interviews included a variety of open-ended questions and scale items (Appendix A).

The interview began with demographic questions that described the target group as well as identified variables that might impact on the achievement of the desired goals of an AIDS educational program. The demographic characteristics assessed were: age, gender, marital status, number of children, level of education, length of time lived in the settlement, and employment status.

The remainder of the interview consisted of a mixture of open-ended questions and scale items about health, sexuality, and AIDS beliefs, and educational learning preferences. The procedure used to collect data describing the beliefs was to introduce the topic using open-ended questions about the belief and then use the appropriate attitude scale items. Questions started with the more general beliefs about health and then became more specific by asking about sexuality beliefs and finally, AIDS beliefs.

AIDS, Health, and Sexuality Attitude Scales. The literature revealed no appropriate tools to measure beliefs towards AIDS or beliefs towards health or sexuality which, according to the AIDS educational model, play key roles in determining the attainment of the desired goals. Thus three attitude scales were developed by Kieren, Judge, and Mahaffey (1988). The 30 items in these scales were generated using concepts from the Health Belief Model (Becker,1974), and attempted to tap areas such as factors that determine the perceived threat of disease, and the probability of taking action to prevent disease as measured by personal evaluation of benefits and barriers. Data from 116 students enrolled in an undergraduate course in human sexuality at the University of Alberta in Edmonton (1988) were used to develop the scales. Factor analyses of the scales revealed that each scale was comprised of subscales that focused on more specific belief areas related to the educational model. The scales and subscales are described as follows:

1. AIDS Scale--measures factors that would influence the probability of practicing risk free AIDS behaviors. The subscales that contribute to this measurement are:
    - a) Motivation for Education - indication of intention to learn more about AIDS
    - b) Risk factors - indication of who is at risk for contracting AIDS
    - c) Disbelief - deterrents for learning about AIDS

d) Fate - personal action will not affect the result

e) Lack of Action - barriers to taking action against AIDS

and although not a subscale as such, the single item called, Safe Sex, gives an indication of an individual's likelihood of taking action against AIDS.

2. Health Scale--measures the general attitudes toward health and health responsibility by measuring two aspects of health:

a) General Health - indication of holistic approach to health and the relationship between health and behavior

b) Spiritual Influences - the place of spirituality in health

3. Sexuality Scale - measures the general attitude towards sexuality factors that could influence both the probability of practicing risk free AIDS behaviors and beliefs about AIDS. This is accomplished by using three subscales:

a) Responsibility for Prevention - indicates who is responsible for preventing the spread of sexual diseases.

b) Sexual Privacy - indicates the individual's beliefs about the effect of sexual openness.

c) Behavioral Responsibility - indication of taking sexual responsibility

The scales and subscales were developed with the intention that their scores would provide some indication of a person's and/or group's relative position on factors which are believed to motivate or deter persons from making necessary behavioral change with regards to AIDS. All items are responded to by indicating the amount of agreement or disagreement with the item using a 5 point scale: (5) strongly agree, (4) agree, (3) undecided (2) disagree, and (1) strongly disagree. Positive attitudes are indicated by a higher score and thus items stated in the opposite direction were recoded before analysis. A low score on a scale or subscale would indicate that it is an area that should be emphasized in an educational program. Also, by looking at the scores, decisions could be made as to whether educational programs should be targeting particular gender or age groups. In addition, individual item analysis could be conducted in order to determine perceptions on specific items.

As these scales have not, at this point, been widely used there are no norms available for them. The reported alpha reliabilities for the AIDS, Sexuality, and Health scales were .81, .70, and .66 respectively.

Preferred Learning Strategies. Following the questions about health, sexuality, and AIDS beliefs were closed and open-ended questions designed to describe the preferred learning strategies of the Metis adults. The strategies to be described consisted of methods and techniques of educational learning such as preferences in visual, tactile, and auditory learning styles, educational settings and format. Thus the interview included questions pertaining to how the Metis adults have acquired their present knowledge of AIDS, and their general preferences as to (a) how AIDS information should be provided to Metis adults (lecture, demonstrations, videos); (b) what format should be used (one-to one, small group or whole community ; one session or several sessions); (c) who should provide the AIDS information (trained community member, community health nurse, educator from AIDS Network or STD Department); (d) when the information should be presented (time of day, day of week, time of year); (e) where it should be presented; and (f) how explicit this information should be. Adults were also asked how useful they felt various types of media coverage, for example, TV, magazines, and pamphlets, were at informing them about health issues.

The last part of the interview consisted of using two scales, one to identify the adult's fear of AIDS and the other, to describe the individual's level of knowledge about AIDS.

Fear of AIDS Scale. This 14 item scale developed by Bouton, Gallaher, Garlinghouse, Leal, Rosenstein, and Young's (1987) was used to measure attitudes towards the fear of AIDS. Participants were asked to assign responses of: strongly agree, agree, undecided, disagree, and strongly disagree to such statements as "I wouldn't mind being in the same room with a friend who had AIDS." Using scores of 0, 1, 2, 3, and 4 to these statements, a score for each adult was achieved by summing the value of the rating obtained from each of the items. Positive items were scored on a scale ranging from strongly agree (0) to strongly disagree (4) and negative items were scored in the reverse order, that is, ranging from strongly agree (4) to strongly disagree (0). A high score on the test indicated a fear of AIDS, whereas a low score indicated relatively little fear of the disease. This scale reported a Cronbach alpha reliability of .80.

Knowledge of AIDS Questionnaire. Information about the participant's knowledge of AIDS was obtained by using an adapted form of a true-false questionnaire developed by the Results Group for use in a study, "Perceptions and Attitudes to AIDS Prevention Among Youths and Parents", done in 1987 for the Edmonton Local Board of Health. The questionnaire was adapted so that language was more appropriate for the current sample and the response to the questions would be "yes" I agree or "no" I disagree with the statement about the disease AIDS. The yes-no approach was used for two reasons: one, as a result of piloting the questions, one individual commented that having to respond that a statement was true or false when she wasn't sure made her feel uneasy ("puts me on the spot") and secondly, from a health educator's perspective, responding true or false without having the opportunity to immediately correct wrong responses, may reinforce incorrect information.

At the end of the interview, the researcher answered the questions asked during the interview about the disease and inquired if the participants had any other questions or concerns. The participants were then thanked for their cooperation and informed that the researcher would contact them later about the date and time for the second part of the survey.

Viewing and Discussion of AIDS Educational Materials

All participants were invited to view and discuss the AIDS educational materials in small groups. Usually these groups consisted of participants from the same gender-age category but on two occasions the groups were mixed; one group consisting of men from all age categories, and the second, a group of men and women in the 31-45 years age group. If participants were unable to attend the group session, they were invited to join another group of the same gender or asked if there was a more convenient time for them to attend. Participants were notified of the group session by phone and/or written notice at least three days before the session. Often participants were a given a reminder phone call on the day of the session and asked if they required transportation. A total of 19 adults participated in seven group sessions, two of whom had not been interviewed (one adult had refused to be interviewed and the other had not been randomly chosen). A detailed description of the adults participating in the assessment of AIDS educational materials can be found in Table 4.2. Attendance at the sessions ranged from 1 to 6 adults.

Specific information about AIDS educational material preferences of Metis adults was obtained through a focused group discussion following the viewing of several different types of AIDS materials. All questions and answers were given verbally except with the participants of the male mixed-age group session who were asked in order to identify age category differences, to respond to the questions by using an answer sheet as well as in discussion. Five different types of educational material (printed information in the form of pamphlets and books, a story, clips about the transmission of the disease from three AIDS educational videos shown in random order, and a demonstration of the proper use of a condom) were viewed (see Appendix A for a description of educational material used). For each type of educational material viewed, focused group discussion was used to identify the following: (a) whether the type of material was seen as a useful way to learn, (b) what they liked and disliked about it, (c) if they could suggest a way to improve the material, and (d) what audience they felt would find it useful.

At the end of the session, any questions the participants had about the study or about AIDS were answered. Often participants expressed disappointment that they did not get to see all of the videos (rather than just a clip) but when invited to stay and watch them, only members of the male mixed-age category group did so. Before leaving, the participants were thanked again for their cooperation and reminded that the information they had shared would be used to develop an AIDS educational program to be offered in their settlement in the near future.

Data Analysis

As the primary purpose of this study was to identify and prioritize the needs of a particular group with respect to AIDS education, a descriptive analysis was the most appropriate. Data derived from the scales and demographic questions were recorded on scanning sheets and computer analyzed using SPSSx. A descriptive analysis consisting of frequencies and /or means was provided. To determine the unique areas of need and to identify any commonly held aspects of need, analysis was done by gender and age category.

Tape-recorded responses to open-ended questions were transcribed and then analyzed in terms of content. Coded responses were sorted using an IBM computer program called Ethnograph, version 3 (1988). Frequencies and percentages of coded responses to many questions were then calculated by gender and age category.

The collected data was then assessed to determine what factors would act as benefits or barriers to the practice of AIDS risk free behaviors and to prioritize the identified needs. This was accomplished in several ways: by looking for patterns of need, that is, outstanding findings such as high/low levels of knowledge and positive/negative attitudes; by testing for similarities and differences in needs both within the Metis adult sample (by gender and age category) and in comparison with other adult groups; and by comparing the findings to the literature. This type of assessment process depends a great deal on the analytical skills of the researcher or programmer. The major findings of the data analysis are discussed in Chapter 5.

CHAPTER 5

NEED IDENTIFICATION

As the AIDS Educational Model in Chapter 2 illustrates, describing the needs of a target group with regards to AIDS education is complex and involves both needs identification and needs assessment. The results of the needs identification survey for a group of Metis adults are organized according to the model components--AIDS Concerns, Individual Perceptions, and Modifiers. Specifics about the transmission of the AIDS disease were used to assist in the identification of need. Because the intent of this research was to provide information for an educational intervention, results are reported for the entire sample as well as by gender or age category, whichever contributed to the best description of need. Quotes from the interviews are followed in brackets by two identification letters which describe the participant. The first letter indicates the age category (A: 18-30 years, B: 31-45 years, C: 46+ years) and the second letter indicates the gender (F: female and M: male).

The assessment of need will comprise Chapter 6 and will include a discussion of the remaining components, that of probability of change and methods to enhance the achievement of the desired goals.

AIDS Concerns

A variety of concerns about the disease AIDS were expressed throughout the interviews. Concern regarding the increasing number of people with AIDS was reflected in responses such as:

> It's surprising how people--many people do get it [AIDS], and it's real scary. (CF)

> . . . it seems to be spreading pretty quickly. (BF)

The awareness among the participants that AIDS is a concern to the heterosexual population was shown in comments linking sexual activity to acquiring AIDS. Several examples are:

> My first thought is a person's homosexual, but then I know it can be--a woman can cont[r]act it too. And children, and whatever. (AM)
>
> You can only get that [AIDS] by having sex with a person that has AIDS. Oh, boy--in that case I wouldn't even try. (CF)
>
> It's a disease . . . that's . . . either bisexually you can get it, or . . or very active sexually. Or gay. (AM)

Concern was also expressed about the future effects of AIDS both in the general population and personally. The following comments reflect these general and specific perspectives:

> I hate it. It's so bad. A lot of this--a lot of good women, they ruin a lot of good girls, a lot of good women, a lot of good persons. A man, the same thing. (CM)
>
> But I know I won't get it now. But what about in years ahead or something, am I always going to feel like that? You know, terrified to go out with another man? (AF)
>
> I think I'd do something to get rid of myself fast [if I got AIDS] instead of worrying other people. (CM)

Approximately 25% of the male participants and 20% of the female participants responded that the thought of AIDS made them feel frightened or scared. A sample of responses reflecting this feeling are:

> It's [AIDS] a new disease that everybody's scared of. (AM)
>
> AIDS sounds so dirty--or not dirty, it just makes chills go up my head . . . I've got this yucky feeling about AIDS. (AF)
>
> You know, that [AIDS] worries a person to death. (CM)

Single persons' comments tended to include a personal concern, for example,

> For me myself, I think it would be important cuz seeing how I'm still young, I don't have a family yet, I haven't really thought about it, no but AIDS could destroy me and my family if I were ever to get it. (AM)

Those in stable relationships or in the older age categories expressed concern for their children or younger siblings rather than themselves:

> This is the worst thing there is, is on earth--that disease to people. It's for the kids. They have it, and they have the kids, that kids is carrying that disease when they were just a little baby. That's a shame. (CM)
>
> I'd like to be able to talk to my kids about it. Because they are the ones that I'd worry about more than myself. (BF)
>
> And it bothers you a bit because although I'm set in my own life, I worry for my children. (BM)
>
> And then I have--my brothers and sisters are all younger than me, I'm the oldest one, and then I'm the only one in a married life, and they're all single and I kind of get scared for them because they all lead the single life and stuff like that, eh? (AM)

One individual expressed her concern about the effect the disease might have on the community this way:

> Well, I think it's something that's really . . . should be of concern to every community, and I've been thinking about it because it was in Grand Centre and I thought, boy, you know, we should really be aware of it because I know it's around. You know, and I was really wondering, gee, you know, there's so many young people out there that are having that--that freedom of like sexual--they're learning and . . . You know, I was really concerned about it because I'm afraid like it might be somebody that I --like everybody here I know. (AF)

One male from the 46+ years age category commented that he was no longer concerned about the disease, stating "It doesn't . . . I don't even hear it anymore. [So when you hear AIDS it doesn't mean anything?] " No, it doesn't mean anything anymore. Not like when they first started to--[put in on the news and the media] and stuff like that. But now, I don't think it's even--they more or less laugh about AIDS." (CM)

Summary of the Metis Adults' Concerns about AIDS

Overall, responses reflected concerns about the increasing number of people with AIDS as well as the fear and anxiety that surrounds the disease. Participants' responses indicated awareness that the disease threatens the heterosexual population and with the exception of the few single participants, the concern expressed was not so much for their personal well-being, but for that of their children and young people in general. A general picture of the concern seen among the participants was expressed by one female in the youngest age category: "It"s a killer. I really don't understand it but when I hear about somebody who has AIDS I get afraid. Well, not really for myself but for that person because I know that there's no cure and there's no way they can turn back." (AF)

Individual Perceptions

The individual perceptions that are seen as a crucial component in the AIDS educational model are the attitudes towards the AIDS disease. Scales and open-ended questions were used to identify the general attitudes towards the disease as well as the individual's fear of AIDS and perceptions of the severity of AIDS and susceptibility to the disease.

AIDS Attitudes

The AIDS Attitude Scale was used to measure general attitudes towards AIDS which might influence the probability of practicing AIDS risk free behaviors. Higher scores indicate more positive attitudes, that is, attitudes that would tend to enhance the probability of practicing AIDS risk free behavior. Table 5.1 reports the mean scores and standard deviations by gender and age category for both the AIDS Attitude Scale and its subscales .

Table 5.1

Mean scores for the AIDS Attitude Scale as a Function of Gender and Age Category

		Males				Females			
SCALE/Subscale		18-30 (n=6)	31-45 (n=6)	46+ (n=7)	Total (n=19)	18-30 (n=11)	31-45 (n=9)	46+ (n=5)	Total (n=25)
AIDS	M	71.2	65.0	62.3	65.9	67.5	67.3	64.2	66.8
	SD	6.1	6.0	4.0	6.3	5.6	5.4	6.0	5.5
Motivation	M	12.3	11.2	11.7	11.7	12.5	12.3	12.2	12.4
	SD	.8	1.8	.8	1.2	1.1	.7	.4	.9
Risk	M	14.7	13.2	12.6	13.4	12.8	13.1	13..2	13.0
	SD	.5	1.5	1.0	1.3	1.5	2.1	.8	1.6
Disbelief	M	16.7	14.8	14.3	15.2	15.3	15.6	14.8	15.3
	SD	3.1	1.5	1.3	2.2	1.8	1.7	2.2	1.8
Fate	M	7.7	6.5	6.7	6.9	7.5	7.3	6.6	7.2
	SD	1.0	2.5	1.7	1.8	1.4	2.1	1.9	1.7
Lack of Action	M	16.0	15.7	13.0	14.8	15.5	14.9	13.2	14.8
	SD	2.9	1.4	2.9	2.8	1.8	3.2	2.8	2.6
Safe Sex*	M	3.8	3.7	4.0	3.8	4.0	4.1	4.2	4.1
	SD	.8	.8	.0	.6	.6	.3	.4	.5

* measured by a single item

AIDS Attitude Scale

The total possible score for this scale was 80. Table 5.1 shows that the mean scores of the gender-age groups ranged from a low of 62.3 for the male 46+ years group to a high of 71.2 found in the male 18-30 years group. An analysis of variance by gender and age category was used to test for significant differences among the group means. Table 5.2 reports the results.

Table 5.2

Two-way Analysis of Variance by Gender and Age Category for the AIDS Attitude Scale

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	231.809	3	77.270	2.540	.071
Gender	.001	1	.001	.000	.997
Age Category	223.961	2	111.980	3.682	.035
2-Way Interactions	81.198	2	40.599	1.335	.275
Gender Age Category	81.198	2	40.599	1.335	.275
Explained	313.006	5	62.601	2.058	.092
Residual	1155.789	38	30.416		
Total	1468.795	43	34.158		

45 cases were processed. 1 case (2.2 pct) was missing.

This analysis showed a significant main effect for age category. Using the Scheffe procedure at alpha = .05 level, the multiple range test indicated that the significant difference seen in the AIDS Scale total mean scores by age category was accounted for by the oldest (M = 63.1) and youngest (M = 68.8) age categories. For both males and females in the 18-30 years age category, the mean scores were higher than mean scores for either the male or female 46+ years age category. One interesting score to note is that the highest mean, 71.2, was recorded in the male 18-30 years group indicating that this group had the most positive attitude towards the practice of AIDS risk free behaviors.

Subscales.

1. Lack of Action. This subscale was intended to measure an individual's belief about taking action to prevent the spread of AIDS. Comparing the subscale mean scores recorded in Table 5.1 showed that the males in both the 18-30 and the 31-45 years age categories scored higher than females in the same age categories, while in the 46+ years age category there was little difference between the scores of the males and females. An analysis of variance by gender and age category was again used to reveal significant differences among the group means. (Note: higher scores, total possible =20, for this subscale indicates a more positive attitude towards taking action that would prevent the spread of the disease.)

Table 5.3

Two-way Analysis of Variance by Gender and Age Category for the Lack of Action Subscale

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	53.224	3	17.741	2.721	.058
Gender	1.524	1	1.524	.234	.631
Age Category	53.196	2	26.598	4.080	.025
2-Way Interactions	1.572	2	.786	.121	.887
Gender Age Category	1.572	2	.786	.121	.887
Explained	54.796	5	10.959	1.681	.163
Residual	247.749	38	6.520		
Total	302.545	43	7.036		

45 cases were processed. 1 case (2.2 pct) was missing.

Age category was again seen to have a significant main effect on the scores. The multiple range test using the Scheffe procedure at the .05 level indicated that the significant difference by age category in the Lack of Action subscale mean scores was accounted for by the oldest (M= 13.1) and youngest (M = 15.7) age categories. Looking back at Table 5.1, it is noted that the reported subscale mean scores were lower for males and females in older age categories.

2. Risk. This subscale was used to measure the individual's perception of the effect of AIDS on health. Mean scores of 14.7 out if a possible 15 on this subscale for the male 18-30 years group indicates that this group perceives AIDS as being a more serious health risk than the other groups do. Analysis of variance revealed no significant differences among the gender or age groups.

3. Disbelief. An analysis of variance indicated that there were no significant differences among the means of the gender and age groups for this subscale. The highest mean score of 16.7 out of a possible 20 was noted in the male 18-30 years category. Scores were lower on this subscale for older males and females, indicating that the older adults felt less threatened by AIDS than the younger adults.

4. Fate. Out of a total possible score of 10, the mean scores by gender and age category ranged from a low of 6.5 in the male 31-45 years group to a high of 7.6 in the male 18-30 years group. Scores for the fate subscale were slightly higher in the 18-30 years age categories for both males and females. Analysis of variance revealed no significant differences among the gender or age groups.

Responses by gender to the two fate subscale items are noteworthy as they point to a perceived view of lack of control with respect to AIDS by a substantial number of people. Thirty-seven percent of the males and 40% of the females respectively responded that they agreed or strongly agreed with the statement "No matter what you do, if you are going to get AIDS it will happen." A similar pessimism was indicated by 11% of the males and 8% of the females having agreed with, and a further 6% of the males and 12% of the females being undecided about, the statement "Practicing safe sex methods to prevent AIDS isn't worth the effort."

Fear of AIDS

The Fear of AIDS Scale was included to assist in identifying if there was a component of fear expressed within the participants' attitudes towards AIDS. The higher scores on this scale indicated a greater fear of AIDS.

Table 5.4

Mean Scores for the Fear of AIDS Scale as a Function of Gender and Age Category

SCALE/Subscale		Males 18-30 (n=6)	Males 31-45 (n=6)	Males 46+ (n=7)	Males Total (n=19)	Females 18-30 (n=11)	Females 31-45 (n=9)	Females 46+ (n=5)	Females Total (n=25)
Fear of AIDS	M	29.2	27.7	31.3	29.5	26.9	25.2	28.0	26.5
	SD	7.5	4.1	4.0	5.3	3.9	6.2	5.0	4.9

When observing mean scores by gender, it is noted that, in general, the males (29.5) had a higher score than females (26.5) indicating a greater fear of AIDS. More specifically by gender and age categories, the highest scores or most fear, are noted for both the males and females in the 46+ years age category, followed 18-30 and then the 31-45 years age categories. The lowest mean score of 25.2 out of a possible 56 was recorded for the female 31-45 years group. Analysis of variance revealed no significant differences in level of fear among the gender or age groups.

The intention of this scale was to measure attitudes toward fear of AIDS. As with the AIDS Attitude Scale there has been no research done to indicate how the scores on the Fear of AIDS Scale relate to behavior. Scores can only show the strength of these attitudes. Comparing the scores of the Metis adults to those obtained by two other groups of adults assists in interpreting the results. Mean scores obtained by 266 males and 258 females enrolled in an introductory class at the University of Texas in 1987 were 32.2 and 31.4 respectively. This indicated that the the University of Texas students had a greater fear of AIDS than the Metis adults. In 1988 the Fear of AIDS scale was given to 24 males and 92 females attending an undergraduate human sexuality class at the University of Alberta with the resulting mean scores of 25.0 for the males and 24.8 for the females. Although the sample sizes vary, it is interesting to note that the level of fear of both the male and female Metis adults, as indicated by the mean scores, falls between that of the two university samples and closest to those of the University of Alberta students.

Perceptions of the Disease

Data from the interview helps to enrich the understanding of the participants' perception of AIDS by providing an indication of how the individual perceives the severity of the disease and susceptibility to AIDS.

Perceived Severity of AIDS. The majority (68%) of the adults when asked what the word AIDS meant to them responded by saying that it was a serious or fatal disease. Some of the terms used to describe AIDS were "killer", "uncurable", and "deadly".

Perceived Susceptibility to AIDS. Perceptions of susceptibility to AIDS were investigated by looking at the likelihood of the individual contracting AIDS as well as the possibility of someone within the community contracting the disease.

Perceptions of individual susceptibility. More males than females thought it was possible that they could get AIDS. Eighty-five percent of the males said that it is possible they could get the disease with 10% of these qualifying the statement that it would depend if they experienced lifestyle changes such as divorce. In comparison, only 52% of the females reported the possibility, with 8% of these dependent on a change in the present situation. Forty percent of the women said that they would not get AIDS (highest number from the 46+ years age category) while only 1% of the men felt the same way. In fact, no one in the male 18-30 years group reported feeling they could never get AIDS. One male commented that he might have AIDS now in this statement, " I could have, for all I know. I might have them. I wouldn't be surprised." (CM)

Perceptions of community susceptibility. Everyone said it would be possible for someone in their community to get AIDS. Five percent of the men and 20% of the women went on to say that it was not only possible but probable.

Some of the reasons given for this perception were:

1) lack of care as illustrated in the following sample responses:

> Yes, cuz nobody really cares. (AF)
>
> That depends on if they don't take care of themselves. (CF)
>
> Yes, I think the younger people are more liable to run into something like that than the older ones. . . they've been more settled. (BF)

and 2) the feeling that their community was not that removed from where the problem (AIDS victims) presently exists as expressed in such comments as:

> Oh, I wouldn't doubt it. 'Cause I mean, it's not that far from where other people come from, you know, 'cause people travel from all over in this area. (CM)
>
> I don't doubt it one bit. In fact, I believe if we're not careful it will pollute the whole world. So I don't think Elizabeth Settlement will be exempt from all that because I'm sure there are a lot of things going on that we don't see. I don't know if I'd want to know everything. (BM)

Summary of the Main Findings Regarding the Metis Adults' Perception of AIDS

1. Metis adults perceived AIDS to be a serious and fatal disease.
2. The majority of the Metis adults, men more frequently than women, felt that it was possible for them to get the disease.
3. Metis adults perceived that AIDS could very likely be contracted by someone in their community.
4. Attitudes towards AIDS indicated that more people would agree, than disagree with the practicing of AIDS risk-free behaviors.
5. Attitudes towards the practice of risk-free AIDS behaviors became less positive in the older groups with the most positive attitudes being noted in the young male group, the least positive in the male 46+ years group.
6. Generally the fear of AIDS expressed by the Metis adults was at a moderate level.
    a. Males expressed a greater fear of AIDS than females.
    b. For both males and females, the level of fear of AIDS was the greatest among the oldest age category, followed by the youngest; with the least fear being expressed by the middle age category.

Modifiers

The AIDS educational model identifies several groups of factors that can modify the perception of AIDS as well as directly affect the desired goals (outcome). The results of identifying the specific factors that act as modifiers will be grouped under the headings: personal characteristics, attitudes toward health, attitudes toward sexuality, knowledge of the disease, and stimulus to act factors.

Personal Characteristics

The proposed conceptual model (Table 2.1) suggested that many personal characteristics have a potential modifying effect on perceptions of AIDS. Some of the personal characteristics of the present sample were determined by the eligibility criteria for participation in the study: race- Aboriginal, ethnicity - Metis, residence - currently living on the Elizabeth Metis Settlement in rural Alberta approximately 300 kilometres from Edmonton, age - 18 years old and over, and language - able to converse fluently in English. The community statistics stated that 90% of the settlement members were of the Catholic religion and that the average family income per month ranged from $800. to $3500. Other characteristics seen as potential modifiers are summarized in Table 5.5.

Table 5.5

Personal Characteristics of Participants by Gender and Age Category

	MALES			FEMALES		
	18 - 30 % (n=6)	31-45 % (n=6)	46+ % (n=8)	18 - 30 % (n=11)	31-45 % (n=9)	46+ % (n=5)
Marital Status						
single	33.3(2)	16.7(1)	25.0(2)	27.3(3)	0.0	0.0
married	16.7(1)	83.3(5)	37.5(3)	27.3(3)	55.6(5)	80.0(4)
commonlaw	50.0(3)	0.0	0.0	36.4(4)	33.3(3)	0.0
widowed	0.0	0.0	25.0(2)	0.0	0.0	20.0(1)
divorced/sep	0.0	0.0	12.5(1)	9.1(1)	11.1(1)	0.0
Children						
no	33.3(2)	16.7(1)	12.5(1)	18.2(2)	0.0	0.0
yes(no adol)	66.7(4)	33.3(2)	50.0(4)	63.6(7)	0.0	60.0(3)
yes (includes adol)	0.0	50.0(3)	37.5(4)	18.2(2)	100.0(9)	40.0(2)
School - highest grade completed						
1 -5	0.0	0.0	25.0(2)	0.0	0.0	20.0(1)
6 -7	0.0	16.7(1)	50.0(4)	0.0	0.0	0.0
8 -9	0.0	16.7(1)	12.5(1)	27.3(3)	44.4(4)	40.0(2)
10 -11	83.3(5)	66.7(4)	0.0	45.5(5)	22.2(2)	40.0(2)
12	16.7(1)	0.0	12.5(1)	27.3(3)	33.3(3)	0.0
Further education - attended						
trade	50.0(3)	83.3(5)	25.0(2)	0.0	55.6(5)	20.0(1)
college	0.0	0.0	0.0	9.1(1)	22.2(2)	0.0
university	0.0	0.0	0.0	0.0	0.0	40.0(2)
none	50.0(3)	16.7(1)	75.0(6)	90.9(10)	22.2(2)	40.0(2)
Employment status						
not employed	33.3(2)	16.7(1)	25.5(2)	63.6(7)	33.3(3)	40.0(2)
full time	66.7(4)	83.3(5)	25.5(2)	9.1(1)	55.6(5)	60.0(3)
part time	0.0	0.0	50.0(4)	27.3(3)	11.1(1)	0.0
Years lived on the settlement						
1 - 2	0.0	0.0	0.0	0.0	11.1(2)	0.0
3 - 4	16.7(1)	0.0	0.0	0.0	0.0	0.0
5 - 10	50.0(3)	0.0	12.5(1)	0.0	22.2(2)	0.0
over 10	33.3(2)	100.0(6)	87.5(7)	100.0(11)	66.7(6)	100.0(5)
Approximate times per week that the individual leaves the settlement						
once	0.0	0.0	12.5(1)	0.0	11.1(1)	60.0(3)
2-3	83.3(5)	66.7(4)	25.0(2)	45.5(5)	55.6(6)	0.0
more than 3	16.7(1)	33.3(2)	62.5(5)	54.5(6)	33.3(3)	40.0(2)

Note. The values represent percentages of response frequency within each gender-age category. Bracketed numbers indicate actual response frequencies.

The approximate number of times per week the individual leaves the settlement usually referred to traveling to the nearest town for groceries, mail, and so forth. Further probing during the interviews revealed that the frequency of visits outside the local area such as Edmonton, varied widely. About half the adults reported that trips to places like Edmonton occurred only occasionally, approximately 1 to 4 times a year, while others traveled more frequently, for example, 1 to 3 times a month. Overall, younger adults tended to travel more frequently than older adults.

Attitudes toward Health

Attitudes toward health were identified through the use of the Health Attitude Scale as well as open-ended questions during the interview. A detailed description of these attitudes are reported according to the method by which they were collected.

The Health Attitude Scale was used to measure the individual's general attitudes toward health and health responsibility. Higher scores indicated a more positive attitude. Table 5.6 summarizes the mean scores for the total Health Scale and its two subscales.

Table 5.6

Mean Scores for the Health Attitude Scale as a Function of Gender and Age Category

		Males				Females			
SCALE/Subscale		18-30 (n=6)	31-45 (n=6)	46+ (n=7)	Total (n=19)	18-30 (n=11)	31-45 (n=9)	46+ (n=5)	Total (n=25)
HEALTH	M	17.8	19.3	18.3	18.5	17.6	19.0	20.2	18.6
	SD	4.2	3.2	2.7	3.2	3.5	2.7	2.5	3.1
General Health	M	11.8	12.2	11.5	11.8	11.3	12.6	13.2	12.1
	SD	2.2	1.3	1.6	1.7	2.8	1.9	1.8	2.4
Spirituality	M	6.0	7.2	6.8	6.7	6.3	6.4	7.0	6.5
	SD	2.2	1.9	1.9	2.0	1.2	1.1	1.6	1.2

The total possible score for the Health Attitude Scale was 25. This is comprised of 15 for the subscale General Health, which identifies an individual's position on the relationship between health and behavior, and 10 for the Spirituality subscale which addresses the influence of spirituality on health. Thus, the reported mean scores would indicate that the Metis adults have a generally positive attitude towards health; that is, one that views health in holistic terms. Analysis of variance failed to reveal any significant differences among the groups. It is interesting to note though, that for the females, attitudes towards health became more positive with age as demonstrated by the increasing mean scores for both the total scale and the two subscales. However, this pattern was not seen for the males where the most positive attitudes towards health as measured by the mean scores for the total scale, were held by the 31-45 years age category.

Interview questions were designed to provide more details about health attitudes by asking questions about the meaning of health, ways to maintain health, both ongoing and when sick, and factors that influence health such as cultural beliefs (in traditional medicine), the church, and incentives necessary for making health related changes.

Meaning of Health

Answering the question of what health meant to them was found by most to be a difficult task. As one participant commented, " It means a lot. I don't know how to answer that."(AF) About half of both the men (55%) and women (56%) who did respond opted to express the meaning of health in physical terms, that is in terms of hygiene, diet, activity, living longer and independence. The meaning of health was also reported in terms of importance to the individual especially in the oldest age category where 87.5% of the men and and 80% of the women responded this way. A few examples of responses used to express the importance of health are:

> Well, for me, it's I guess the most number one priority in life. You know, I value my life very much. (CM)
>
> I think it's the greatest thing in life. (CM)
>
> To me, to be healthy is the most wonderful thing in the world. (CF)

> It means to me--to be healthy means everything to me. Everything--you know. (CF)

About half of the women (56%) described health in holistic terms with such comments as " I think that's the bottom line. If you're healthy then you can be happy, then you have a lot going for you."(AF); and "To be healthy means to take care of yourself and your body. I once heard a saying, in order to be successful you have to have a clean mind, body and spirit."(BF) Only about a quarter of the men reported viewing health holisticly. They had a greater tendency (approximately 35%) to describe health in terms of absence of disease, while only 24% of the females referred to health in these terms. Ten percent of the males and 32% of the females included psychological aspects of health such as happiness and self esteem.

Ways of Keeping Healthy

When asked specifically about the ways they used to maintain their health, 100% of the men responded that the way to keep healthy was through lifestyle activities such as exercising (80%), working (60%), not drinking (25%), and not smoking (10%). Seventy-two percent of the women also mentioned lifestyle as having an influence on their health and again exercise (64%) was the most frequently mentioned, followed by fresh air (20%) and work (12%). Forty percent of the men and 92% of the women reported physical factors such as diet, rest, and hygiene as having an effect on health. Only 10% of the men and 32% of the women mentioned prevention such as physical check-ups, dental check-ups and immunization as a way to maintain health.

The Metis adults reported a variety of sources for learning how to stay healthy. The main way cited by both the men and women was through the experience of growing up. In descending order of frequency of reporting, the men gave the following sources as influencing their present ideas on how to maintain health: life experiences (60%), media-books, TV, magazines (20%), friends (15%), and school, family and generally people one knew (each accounted for 10%). Although 48% of the women also saw life experiences as teaching them ways to maintain health, other factors that contributed to their knowledge were reported to be: school and family (each 32%), media (20%) and people and professionals (each 12%). One individual accounted for his methods of staying healthy by saying, "Well, just part of my life, part of my culture." (BM)

Further insight as to how the participants viewed health was gained by asking what they do when they are not feeling well. Seventy percent of the males and 72% of the females replied that they would first treat themselves by trying such things as resting, taking non-prescription medication, or getting fresh air. In fact, 4% of the females and 5% of the males said they would just ignore the illness while another 15% of the males said they were not sure because they were never sick. Only 10% of the males and 16% of the females when ill would immediately seek assistance from the doctor.

Traditional Medicine

Questions were also asked to discover what role traditional medicine presently played in maintaining health. The term traditional medicine included two distinct areas: the use of herbs and roots, and the use of medicine men or women. Sixty-five percent of the males and 60% of the females said they believed in the use of herbs and roots (higher in older males and younger females). Explanations for their belief in the use of herbs and roots ranged from, "No, cuz you don't know what you're taking."(AF); to "I guess it's got something to do with if you believe in it or not to--if it worked"(AM); and "I guess I have in a way to agree with that because it's part of our tradition. And I've seen it work"(AM). Many stated their belief in herbs and roots would depend on the particular situation: "I suppose if I knew for sure that the root would work, I suppose it would be all right but I don't know anything like that."(BM), or "It all depends on what type of sickness or kind of disease a person has."(CM) Two reasons were given to explain the use of herbs and roots; one that they are less expensive than going to the pharmacy, and second that "there's no chemicals in them". The inconvenience and time factor of having to go in the bush and find the necessary herbs and roots was given as the main reason to explain why some people who believed in herbs and roots didn't use them. Although many stated that they did not personally know which herbs/roots to use for which ailments, they did state they knew who to go to get this information.

When asked specifically if they believed in the medicine man or woman, 20% of the males and 16% of the females agreed. Most reported that they would consider seeing the medicine man/woman only for serious ailments that the doctor had failed to cure or for problems that might be the result of someone using "bad" medicine on them. The majority of the adults do not believe in using the medicine man/woman. Examples of comments expressing this point of view are:

> I find that kind of hocus-pocus myself. The herbs, you can see that, but a medicine man I know doesn't seem to . . . it has a . . . I don't know, kind of like a voodoo thing. (BF)
>
> I don't really believe in stuff like that. I don't believe in stuff like that I don't--it just don't seem real. (BF)
>
> They scare me. . . . It's 'cause I don't know anything about them. I'd rather go to a doctor--a real doctor. (AF)
>
> Maybe--I probably would believe in herbs, but not now. Anything else I figure is just witchcraft. (BM)

Others tried to explain why they would use herbs or roots but not the medicine man/woman --"It seems too spiritual for me, kind of throws me off, I don't know if my faith is in to it, no I don't think I would."(AF); and "No, that's . . . see, that's too strong a believer."(AM) Many are still uncertain as to whether they would see a medicine man/woman--"I don't know, it depends on how sick I was. I don't know, I'd have to be there at the time, in the situation at the time to say for sure, eh."(AM) All agreed that you had to believe in the medicine man/woman for it to work:

> I guess it's got something to do with if you believe in it or not to, eh, if it worked. (AM)

> You have to make up your own mind and you have to believe. If you don't believe, it's not going to work for you. And it's hard to decide if you trust the man that's going to do it. Is he going to deal more evil than good--you know? (AF)

Traditional medicine has a spiritual component --one female referred to her experience with the medicine man --" Oh I drank a few [teas] , yeah. And the rest is spiritual."(AF) and another when talking about an elder ("old lady") who had doctored him with Indian Medicine --"Well, that's what she told me, she said if you pray and believe in God and that God put these things here for her to cure you she said that is all it takes. It's a combined way of healing. And it works, I'm living proof."(BM)

Two other observations from the interview data can be made. One, those who said they believed in traditional medicine were more likely to have been exposed to its use as a child, and two, several participants expressed their belief in 'natural cures' such as the use of garlic onion for gastrointestinal problems or high blood pressure as well as various mixtures of soda, salt, and sugar to cure children's ailments such as diarrhea. A source of information for "natural cures" appeared to be a local pharmacist.

The Church's Influence on Health

The possibility that the church was seen as an influencing factor in maintaining health was investigated by asking if the church sometimes helped them make decisions about their health. Although the church was seen by 60% of the men and 68% of the women as not influencing health decisions, others felt that the church did influence them in such areas as the use of alcohol and tobacco and dealing with stress. Because the question asked specifically about the church's influence on making health decisions, there was some confusion in responses. The following remarks illustrate this confusion and show that the church does contribute indirectly to the maintenance of health :

> The church? I don't think so. Not that I know of. I'm always there. Like we had a prayer meeting last night, but it sure makes you feel good. (CF)

> Not that I know of. Like I told you, being committed to the Lord has a lot to do with the feeling good of it. (CF)
>
> I don't think so. Theirs is more of a mental attitude than a health thing. (BF)
>
> Well the church plays a big part in my life. Well, the church plays a big part with everything, relationships with people, with my health--I don't know. During Lent I really watch what I eat. (AF)
>
> I don't think about the church, but I know God, I believe in God and I believe in Jesus and I think that has a lot to do with a person's emotional state. And I think if a person is emotionally healthy they are going to be healthy inside out and a person starts to be unhealthy in their emotional state and mental state it is going to affect their physical, that's what I think. (AF)

Making Health Behavior Changes

Individuals were also asked about making changes to promote health. The majority of both men and women responded that they would be willing to change what they were doing if they found out it could possibly make them sick. However, 75% of the men and 44% of the women said that for this change to take place they would have to experience some, usually serious, effect. Examples of responses illustrating this are:

> Something would have to happen that would affect me directly. (AM)
>
> Depends . . . if it made me really sick, if I knew what was the cause, I'd quit. (AF)
>
> Probably it would have to be serious, you know, seriously sick to do something about it. [So you would actually have to feel sick before you would get around to doing anything?] Ummhuh. (CF)

Only 15% of the men and 16% of the women said they would make changes in response to having only knowledge of serious consequences of health behaviors. Some explanations for the lack of response to knowledge of serious consequences of health related behaviors were that they knew people who had, without suffering, engaged in health behaviors that were known to have serious consequences, for example, " like my Dad, he smoked all his life and he lived till 84. But he didn't die from lung cancer. He just died of old age."(BM) or since there was no evidence of a serious problem, why be concerned --"I've never known anybody to be that sick, it it doesn't scare anything by it, eh. Maybe if I did it would change my point of view."(AF) Distrust of what is read was also indicated as a reason for not responding to information alone: "Cause I know I've read quite a few things that says that this is no good for you, and yet we've been either eating it or drinking it for years and it's never had any effect on us, you know, so it all depends."(BF) The following response illustrates the effect that contact with the negative consequences of disease has on behavior changes, "Well I quit smoking because my father passed away-- he had emphysema. That's one. And well, I'm supposed to be watching my diet, but that's kind of hard."(BF)

Community Needs regarding Health

When asked what they thought was needed in their community to either maintain health or improve it, 20% of the men and 16% of the women felt there was nothing needed. Thirty -one percent and 48% respectively of the men and women who felt that there were some things that if provided in their community could improve health, suggested more health information on various aspects of keeping healthy would be beneficial. This need was expressed by both men and women three times more often in the youngest age group than either the middle or oldest age categories. Some areas mentioned where more information would be helpful were smoking, drinking, diets and nutrition, child care, and exercising safely. The present sources of health information are reported to be doctors, the community health nurse and representative and printed material especially books. Other areas of need mentioned were new facilities such as a health centre with a doctor, a sports centre with a swimming pool and a gymnasium, and a laundromat with showers, and increased access to physical activities such as aerobic and yoga classes.

Summary of the Metis Adults' Health Attitudes

1. Metis adults have a generally positive attitude towards health, that is, an attitude that would facilitate taking responsibility for personal health.
2. Among females, attitudes towards health became more positive as they advanced in age. However, this pattern did not hold for men, where the most positive attitudes were held by the 31-45 years age group, followed by the oldest, with the youngest age group having the least positive attitude.
3. Metis adults tend to see health from a holistic viewpoint.
4. Spirituality plays a [significant] role in health for Metis adults.
5. Health was described using a variety of terms that could be placed in the following categories: physical, psychological, and holistic. Half of the adults described health using physical terms such as hygiene, diet, activity, living longer, and independence. Reference to health in terms of importance was especially noted in the oldest age category for both men and women. More women than men described health holisticly, while men had a greater tendency to refer to health as the absence of disease.
6. There was some variation among the Metis adults as to ways of maintaining health. One hundred percent of the men and 72% of the women reported that lifestyle activities impacted on their health. Exercise was the activity most frequently reported by both men and women to effect health, followed for men by work, drinking and smoking, and for women, by fresh air and work.
7. Metis adults felt that they had learned the ways to maintain health mainly through the experience of growing up. Men reported more frequently learning about ways to stay healthy from printed material, that is, books and magazines, whereas women tended to feel that they had learned these ways from school and family more than through printed material. The present sources of health information were

reported to be doctors, the community health nurse and representative, and printed material, especially books.

8. When sick, most Metis adults attempt to treat themselves by trying such things as resting, taking nonprescription medicines, or getting fresh air.
9. The majority of Metis adults believe in the traditional use of herbs and roots, although they may not actually use them.
10. Of the less than 20% of the Metis adults who believe in the medicine man/woman, the majority would restrict their use to serious ailments that the doctor had failed to cure or to problems that might have resulted from someone using "bad" medicine on them.
11. The use of the medicine man/woman requires a strong spiritual belief.
12. Metis adults who were exposed to the use of traditional medicine (Indian Medicine) as a child were more likely to report that they currently believed in it.
13. Although some did not believe in traditional medicine per se, they reported a preference to use "natural", not chemical, cures when they were assured they would work.
14. Although the church was not seen by the majority of Metis adults as having a direct effect on health decisions, the church's positive influence on health was expressed. It was in the areas of drinking, smoking, and management of stress that the church was reported to have a direct influence on health decisions.
15. The majority of Metis adults would be willing to change health behaviors if they found out these could possibly make them sick. However, 75% of the men and 44% of the women said that they would have to experience some effect, usually a serious effect, for this change to take place.
16. Only a small portion (approximately 15%) of the Metis adults reported that they would change a health behavior in response to only knowledge of serious

consequences. Reasons given for the lack of response to knowledge of serious consequences of health behaviors were that they knew people who engaged in behaviors known to have serious consequences who had not suffered any serious consequences so why be concerned, that habits such as smoking were hard to break, and distrust of written information. Where there had been exposure to negative consequences of health behavior, change had taken place.

17. Four-fifths of the Metis adults felt that their health would benefit if the community could provide more health information in areas such as smoking, drinking, diets and nutrition, child care and exercising safely; more physical activities, for example, aerobics and yoga classes; and additional facilities such as a health centre with a doctor, a sports center containing a swimming pool and gymnasium, and laundromat.

Attitudes toward Sexuality

Again a description of attitudes, in this case toward sexuality, was achieved by using both an attitude scale and open-ended questions. Scale results will be reported first followed by the findings of the content analysis of data obtained from the interviews.

Sexuality Attitude Scale

The Sexuality Attitude Scale was used to identify the individual's general attitudes towards sexuality by looking at the areas of responsibility for preventing sexual disease, sexual privacy, and behavioral responsibility in sexual matters. Higher scores indicate more positive attitudes toward sexuality , that is an attitude that would facilitate the practice of sexual responsibility. The most positive attitude is indicated by a score of 40 on the Sexuality Scale and 15, 15, and 10 on the subscales, Responsibility for Prevention, Sexual Privacy, and Behavioral Responsibility respectively. Table 5.7 summarizes the mean score results by gender and age category for the total scale and the subscales.

Table 5.7

Mean Scores for the Sex Attitude Scale as a Function of Gender and Age Category

		Males				Females			
SCALE/Subscale		18-30 (n=6)	31-45 (n=6)	46+ (n=7)	Total (n=19)	18-30 (n=11)	31-45 (n=9)	46+ (n=5)	Total (n=25)
SEX	M	31.0	31.5	28.8	30.3	33.6	31.7	31.2	32.4
	SD	2.3	1.9	2.6	2.7	3.1	2.9	1.6	2.9
Responsibility for prevention	M	13.8	13.0	11.4	12.6	12.7	12.4	12.0	12.5
	SD	1.5	1.5	.9	1.6	1.6	1.6	.7	1.4
Sexual privacy	M	10.3	11.7	9.5	10.4	12.9	11.2	11.2	12.0
	SD	2.3	.8	2.2	2.0	.9	1.9	.8	1.6
Behavioral responsibility	M	6.8	6.8	7.9	7.3	8.0	8.0	8.0	8.0
	SD	1.3	1.0	.4	1.0	1.2	1.1	1.2	1.1

To reveal if there were any significant differences in responses by either gender or age, an analysis of variance was run for the Sexuality scale and its subscales. The results are as follows:

Table 5.8

Two-way Analysis of Variance by Gender and Age Category for the Sexuality Scale

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	99.273	3	33.091	4.603	.007
Gender	31.971	1	31.971	4.448	.041
Age Category	45.983	2	22.991	3.198	.052
2-Way Interactions	13.582	2	6.791	.945	.398
Gender Age Category	13.582	2	6.791	.945	.398
Explained	112.855	5	22.571	3.140	.018
Residual	280.345	39	7.188		
Total	393.200	44	8.936		

45 cases were processed. 0 cases were missing.

The analysis of variance showed a main effect for gender. As gender includes only two groups a Scheffe was not necessary to determine which groups were higher on the

Sexuality Scale; the females (M=32.4) scored significantly higher than the males (M=30.3). To examine this attitude more closely, tests of significance were also done for the subscales that attempted to measure the beliefs that influence the attitudes towards sexuality.

Subscales.

1. Responsibility for Prevention

Table 5.9

Two-way Analysis of Variance by Gender and Age Category for the Responsibility for Prevention Subscale

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	18.834	3	6.278	3.175	.035
Gender	1.809	1	1.809	.915	.345
Age Category	18.674	2	9.337	4.722	.015
2-Way Interactions	5.253	2	2.627	1.328	.277
Gender Age Category	5.253	2	2.627	1.328	.277
Explained	24.088	5	4.818	2.436	.051
Residual	77.112	39	1.977		
Total	101.200	44	2.300		

45 cases were processed. 0 cases were missing.

While males and females do not differ significantly in their belief about taking responsibility for preventing the spread of sexual disease, the ANOVA did show a main effect for age category. The multiple range test using the Scheffe procedure at the .05 level indicated that the significant difference in mean scores by age category for the Responsibility for Prevention subscale was accounted for by the oldest (M= 11.6) and youngest (M = 13.1) age categories.

2. Sexual Privacy

Table 5.10

Two-way Analysis of Variance by Gender and Age Category for the Sexual Privacy

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	43.103	3	14.368	5.391	.003
Gender	17.596	1	17.596	6.603	.014
Age Category	16.063	2	8.032	3.014	.061
2-Way Interactions	17.765	2	8.883	3.333	.046
Gender Age Category	17.765	2	8.883	3.333	.046
Explained	60.869	5	12.174	4.568	.002
Residual	103.931	39	2.665		
Total	164.800	44	3.745		

45 cases were processed. 0 cases were missing.

Differences in belief about sexual privacy were accounted for by a gender main effect in which the males had significantly lower mean scores (10.4) than the females (12.0). It was also noted that there was a significant interaction between gender and age category. To investigate the interaction effect, a multiple range test using the Scheffe procedure at the .05 level was run. The results indicated that the significant interaction between age and gender in the Sexual Privacy subscale was accounted for by oldest males (M = 9.5) and youngest females (M =12.9) age categories. That is, the oldest males would be significantly less open about sexual issues than the youngest females.

3. Behavioral Responsibility

Table 5.11

Two-way Analysis of Variance by Gender and Age Category for the Behavioral Responsibility

Source of Variation	Sum of Squares	DF	Mean Square	F	Sig of F
Main Effects	9.093	3	3.031	2.654	.062
Gender	7.867	1	7.867	6.888	.012
Age Category	2.843	2	1.421	1.244	.299
2-Way Interactions	2.366	2	1.183	1.036	.365
Gender Age Category	2.366	2	1.183	1.036	.365
Explained	11.458	5	2.292	2.007	.099
Residual	44.542	39	1.142		
Total	56.000	44	1.273		

45 cases were processed. 0 cases were missing.

The ANOVA indicated that males and females had a significantly different belief about taking sexual responsibility. Females had a more positive (M= 8) belief than did the males (M=7.3).

Data from the open-ended questions addressing the areas of comfort with discussing the topic of sex, learning about sex, and sources of sexual information contribute further to the description of sexuality attitudes.

Comfort with Discussing the Topic of Sex

Generally the adults explained that the difficulty many people had in talking about sex was due to the way they had been raised. Frequently participants mentioned that sex was a topic that was not openly discussed when they were growing up. Some of the reasons they gave for this were that sex was too personal to talk about, that is, "traditionally Native people were taught to respect their bodies. . .not to show off their bodies publicly, you know. Or even within their family, just themselves."(BF); that sex was seen as dirty or a sin; and that many people, perhaps due to ignorance, were too embarrassed or shy to discuss the subject. One participant summed it up this way:

> I think that the Indian and that. I believe that . . . for our mothers and fathers, for me anyway, we weren't allowed to talk about things like that. No one ever told you the facts of life. Everything's experimental. I think that they felt it was a sin to talk that way, that they felt it was dirty to be associated with sex in any way and that's the way we were taught when we grew up, not that we obeyed or anything, it was something you didn't talk about. (BM)

Despite the way they were raised, the majority of adults felt things were changing. They reported that they could now talk more openly about sex especially with other adults. However, there still appeared to be some concern about discussing sexual issues with their children. An example of a response that expresses this perspective is: " I think that if I talk about sex with someone it is not so bad but to talk about sex and how everything is with my children I am still nervous."(BM) One participant explained the difficulty in talking about sex with children may be due to lack of information--"To some it's too personal. It's a hard, hard thing to talk about if you don't know how to tell your children about it."(AF)

Learning about Sex

Of those who mentioned how they had learned about sex, the main sources of sex information had been peers and older siblings, experience, and the media (books, magazines and movies). Only a few said their parents had talked to them about sex and often this was described as informing them not to run around or get in trouble. Two males and two female both from the youngest age category reported having received some sex information about the process of maturation and sexually transmitted diseases at school. About 25% of the adults had attended a talk about sex as an adult. Topics covered in these talks were usually birth control or sexually transmitted diseases. All the males reported this information had been part of a premarriage course while females mentioned having attended special sessions sponsored by the health unit, Alberta Vocational College (AVC), or the home economist.

The men felt that presently in their community the children continued to learn mainly by trial and error, for example, "They learn from parties. Guys and girls, they party together, get drunk and that's it."(AM) Peers and media were also mentioned as sources of information for the teens in the community. Not one man mentioned they thought parents taught their children about sex. Meanwhile, the women reported that the school was now playing an important role in teaching children about sex. In addition, women felt that children continued to learn about sex through their peers and siblings, the media, and general experience. Two women (from the 31-45 years category) said they thought parents were teaching their children.

Although most adults reported that they could and should talk to [teach] their children about sex, they frequently mentioned that they didn't think many other parents were actually talking about sex with their children. For example: "They [parents] should talk to their children, but most parents don't."(AF) The following quote describes what one female thought children should know about sex:

> I think that they should know what it's all about. What it's for and what it can do, and why we have to have it. And they should learn that they shouldn't abuse it. Like use it for --to make money or just go around and--you know, and just go with different boys just for the fun of it. So I really don't know. But if I were a girl all over again, I would've liked to have known all about it. (CF)

The school was reported by all but one adult (a female in the 18-30 years category) to be an appropriate source of learning about sex. A variety of reasons were given, such as "If they don't learn it at home, I think they should learn it at school"(AF) and ". . they believe in teachers more than they'll believe their parents. . . Even the little ones. You know, you tell them things, and they don't actually believe you until it's actually been taught by the teacher."(CM)

While most expressed the opinion that parents and schools should work together--"Parent's job. The school can help."(BF);"It should start at home and then carry on in school."(AF); and "The parents still have to tell the children that you have to respect sex."(BM05,), some parents see their involvement as a somewhat difficult task--"I think they [parents] should be involved in it in some way too, but then yet it's kind of hard."(CF) and others as an inevitable one--" I'm sure that they [parents] would have to talk with the children, too . . . because if they like take it at school, they're going to come home and ask questions about it."(AM).

Some advantages for both the child and the parent of sharing the task of teaching about sex are expressed in the following responses: "Some kids are shy and they can't ask their parents. Or vice versa. They can--you know, what they can't ask the teacher, they should be able to come and ask the parents, mother or father."(CM); and "What he learns the kid can tell his parents. Then his parents would decide what's what. And maybe the parent would have a little better knowledge of things like that." (CM). Others noted the drawbacks: "I don't think parents talk enough to their kids about it. I think nowadays parents just leave it up to the schools--with that sex education and all, I think they pretty well just leave it at that."(BF)

When asked who should teach about sex in school, the majority of adults reported that they felt the community health nurse should be the one. They elaborated on this by listing some of the qualities they felt the person who taught about sex should possess. The qualities mentioned were: knowledge of the subject, a healthy attitude about sex, trust of the students, training in knowing how to talk to students about sex without making them uncomfortable, and the ability to be a positive role model. (This was defined by one individual as having a strong marriage and children.)

Sources of Sexual Information

Family doctors were seen most frequently by both men and women as sources of sexual information. Other sources repeatedly mentioned by the men were friends and printed material. In contrast, women tended to see the health unit (community health nurse and the community health representative) as a source of information along with family members, usually sisters or cousins. Like the men, printed material was also seen by the women as providing sex information.

There was overwhelming agreement in response to a question asking if parents needed some assistance in being able to talk to their children about sex. Only three individuals felt they could manage on their own, all others indicated that access to more information would be helpful. Some responses that show the need for providing assistance to parents are:

> Yes, because parents don't always know everything. (AF)
>
> Yeah, there's lot that probably they're nervous about it, eh. Because they were never told about it theirselves, right. (AM)

> I think that's about the only way [providing assistance to parents regarding teaching about sex] that . . Like I said, if a parent hasn't already, then probably it's because they don't know how, how to go about it, and if they had help, it . . . I'm sure it could change some attitudes. (AM)

Types of information that adults thought would be useful ranged from the basics which would answer these concerns: "You don't know how to explain to an eight-year-old about --you know, you don't know how to begin."(BF); and " . . . to show them or tell them how they can do it [talk to children about sex], and at what time, and--you know, like . . . and what to say."(CF) to more specific topics such as "learning to show their emotions openly." (BF); "how about going and telling your child about sex, not feeling like you're guilty or whatever, trying to hide it from them."(BM); information about sexual diseases; and dealing with the concern that teaching about sex will lead to experimentation. A few made comments that reflected their desire to have access to information as it was required, for instance,

> That's a hard question. I probably won't be able to answer that, but . . like you just have to wait and see until you've been approached by your child and so you'll know what is going through their mind, and are you able to answer his or her questions. If not, then you -- you know, a parent should know or would like to know where you can get more information. (AF)

The outcome of assisting parents in this area was expressed by this male, " I think that once I knew what to say to them, I would really talk to them about it [sex] because I feel I love them enough to do that . . . "(BM)

Homosexuality

Although not directly asked about their attitude toward homosexuality, several participants did make comments. These comments showed that the acceptance of the homosexual varies:

> It's not acceptable to me anyway, but who am I to judge a person the way he is. Like each person is his own individual and you must respect them for what they are. Like if you are a Christian or a believer, it doesn't talk about homosexuals in the Bible. Like in our community when I was growing up there is no such a thing . . . so it is really hard

> to talk about it. I know of one or two cases now within our settlement of guys being homosexual but they don't really stick around because there is no way you can fit into this community if you are homosexual. You get laughed right off there. So to the Native people it is not acceptable at all. Yet in my way of thinking, that's myself, I have no right to judge anybody. Only God has a right to judge. So it is a real tough question. (BM)

Another when asked if homosexuals would be accepted in the community replied "most likely"(BM).

Referring to the treatment some of the homosexuals received on a TV forum about AIDS one male said,

> I really felt bad for them. Because what they were doing were talking about themselves, they didn't have to, they could die in peace but they were doing it for what reason, so other people don't get it, eh. And yet people were knocking them down for it. I really felt that to knock those people down, like they're willing to talk about something that is so private yet it is destroying them, yet they want to help people and these people are still knocking them down. What else can you do? They're going to die. They know they've destroyed themselves. (BM)

One female suggested having someone with AIDS talk at a community workshop on AIDS. When asked if it would be a concern if the AIDS victim was homosexual she responded this way: "I don't think there'd be anything wrong with that. He could maybe explain to the people not to be gay or something." (BF)

Younger men tended to refer to homosexuals jokingly using such terms as faggots. One male, when discussing the AIDS commercials, made this comment: "They should take that guy out of there and put someone that doesn't look like a homo." (AM)

Summary of Attitudes toward Sexuality

1. Metis adults generally have a positive attitude towards sexuality, that is, an attitude that would facilitate the practice of sexual responsibility.
2. Females have a more positive attitude than the males.
3. The youngest (18-31 years) age category have a more positive attitude toward taking responsibility to prevent sexual disease than the oldest (46+ years) age category. That is they tend to see that preventing sexually transmitted diseases is an individual

responsibility, not the sole responsibility of either the female, male, or medical expert.

4. Males view sex as being more private than females. They also see the discussion of sexual matters as having a more negative effect on romance than females do. These different views are especially noticeable between the male 46+ years group and the 18-30 years female group.
5. Females have a more positive attitude towards sexual behavioral responsibility, that is they would be more inclined to practice safer sex, than the males.
6. When growing up, the belief held by most of the Metis adults was that sex was a taboo subject, often being referred to as sinful and dirty.
7. Metis adults see the subject of sex as being more open now, and the majority feel they could discuss the subject, especially with other adults.
8. The majority of men see the children in their community continuing to learn about sex the way they did, that is through experimentation, peers and older siblings, and the media. In contrast, women saw the school now playing a bigger role in sex education although peers, the media, and personal experience were also mentioned as contributing to the sexual knowledge of today's children. Females also mentioned that more parents are talking to their children about sexual matters.
9. Adults see sex education as starting in the home and being continued at school.
10. School sex education should be taught by a person who has the following qualities: knowledge of the subject, a healthy attitude about sex, trust of the students, training in knowing how to talk to students about sex without making them uncomfortable, and the ability to be a positive role model. These qualities were often seen to describe the community health nurse.
11. Sources of sexual information for the Metis adults were the family doctor, friends and siblings or cousins, printed material, and the health unit.

12. Parents would like further information on the subject of teaching children about sex; answering such questions as when, how, and what children should be told about sex.
13. Metis adults hold varying views on homosexuality which range from acceptance to rejection on religious and cultural grounds.

Knowledge of AIDS

The individual's actual knowledge of the disease AIDS is seen as the fourth group of factors that act as modifiers. The main method of obtaining the individual's knowledge of AIDS was by using a true-false questionnaire. Data from the content analysis of the interview provided further insight as to the Metis adults' knowledge of the disease as well as how they acquired this knowledge.

Results of the Knowledge of AIDS Questionnaire, which are summarized by gender and age category in Table 5.12, show that the Metis adults do know the basic facts about the disease but are confused with some of the details of disease transmission. Adults in the oldest age category, especially the men, appear to have the least accurate knowledge of the disease.

Table 5.12

Knowledge Level of AIDS by gender and age category

		Valid % with Correct Response					
		Males			Females		
Knowledge of AIDS Questions	Correct Response	18-30 (n=6)	31-45 (n=6)	46+ (n=7)	18-30 (n=11)	31-45 (n=9)	46+ (n=5)
A cure is available for AIDS.	False	100	83	57	100	89	100
AIDS affects both men and women.	True	100	100	100	100	100	100
AIDS can be prevented.	True	100	100	100	100	100	60
Illegal needle drug users are more likely to get the AIDS virus (germ).	True	100	100	100	91	100	100
AIDS is caused by a virus (germ).	True	100	100	100	100	100	80
Drug abuse, not homosexuality, is the most common risk factor for AIDS.	False	17	50	29	64	44	60
Everyone who gets the AIDS virus will die from it.	False	50	17	29	9	33	0
The only way to protect yourself from getting AIDS is by wearing a rubber condom (safe).	False	83	83	29	64	78	60
AIDS is only passed through sexual contact.	False	100	100	57	100	56	40
People who use needles for medical purposes are more likely to get the virus.	False	100	100	43	100	89	80
A person can get AIDS by giving blood.	False	50	67	29	82	56	20
A person can get AIDS from handling pets.	False	83	83	43	100	89	100
A person can get AIDS from insect bites.	False	50	67	57	73	67	80
A person can get AIDS from food, dishes or other objects.	False	67	100	29	100	78	80
A person can get AIDS from kissing.	False	83	83	14	73	100	60
A blood test tells if you have AIDS.	True	100	83	86	91	89	100
People who use drugs or alcohol are more likely to get the virus (germ).	True	50	83	83	36	44	100
Having the AIDS virus (germ) is the same as having the disease.	False	17	50	0	46	56	20
The AIDS virus (germ) can be spread through casual contact, such as touching or being near someone with AIDS.	False	100	83	43	100	78	100

Note. Percentages refer only to those responding correctly to the statement within each gender-age category.

Summary of Knowledge of AIDS

Whereas the majority of the Metis adults knew that AIDS is the result of being infected by a virus, the least known fact was that having the AIDS (HIV) virus is not the same as having the disease. Also only 50% or less in each group was aware that not everyone who gets the AIDS virus will die from it. In fact, 100% of the 46+ years female group believed that everyone who gets the virus will die as a result. In addition, 40% of this group did not know that AIDS could be prevented. Older adults tended to know less about the specifics of disease transmission but were more aware of the possibility of getting AIDS when under the influence of alcohol or drugs than younger adults. All the Metis adults need information about whether or not you can catch the virus from insect bites or by giving blood. The older adults, in particular, appear to need information about the possibility of getting AIDS through casual contact and kissing. When asked if they would like to learn more about the disease, all participants said they would.

Stimulus to Act

The final modifying component is composed of factors that would stimulate the individual to take some action with regards to AIDS. These factors have been grouped and are reported under the following headings: contact with AIDS, direct and indirect educational sources of AIDS information, and preferred learning strategies. Content analyses of the interviews and the focused group sessions were used to obtain the following results.

Contact with AIDS

No one interviewed had had any close contact with an AIDS victim. In fact, no one had even knowingly talked to an AIDS victim. In the 18-30 year age category, one male and one female had each heard of an acquaintance who had AIDS but neither of these individuals had seen the AIDS victim for years and definitely not since the AIDS diagnosis had been made. The closest contact with a possible AIDS victim was reported by one female who said, "I saw one guy in--I went to the pilgrimage in Lac Ste. Anne. He had this AIDS--oh, he was pale and. . . just white as that dish there." (CF) One male said that he had a friend who's daughter had AIDS, got it through shooting up, and inferred that as a result he had learned a lot about the disease.

Direct and Indirect AIDS Educational Sources

The Metis adults have obtained their present knowledge of AIDS from a variety of sources which have been summarized in Table 5.13.

Table 5.13

Reported Direct and Indirect AIDS Educational Sources by Gender and Age Category

	Males			Females		
Source	18-30 (n=6) %	31-45 (n=6) %	46+ (n=7) %	18-30 (n=11) %	31-45 (n=9) %	46+ (n=5) %
INDIRECT (MEDIA)						
Newspapers	83	50	29	73	44	20
TV: news	50	33	29	9	44	0
programs/documentaries	50	33	29	64	56	0
commercials	67	67	0	18	56	0
movie	0	0	0	0	0	20
soaps	0	0	14	18	56	60
Magazines	--	--	--	27	33	40
Books	0	0	0	0	0	0
Pamphlets on AIDS	67	0	14	73	33	60
DIRECT						
Information sessions on AIDS	0	0	0	18	11	0

-- not asked this question

Indirect Sources of AIDS Information

Newspapers. Although many of the Metis adults had seen articles about AIDS in newspapers, the following responses indicate that this is not a good source of information:

> I've read some articles, but I can't remember what they were about. (BM)
>
> I've seen a lot of it [in the newspapers] but not really read it through. (CF)
>
> I don't even bother reading them because a lot of it is not true anyway. (BF)

Television. Seventy-five percent of the adults reported having seen something about AIDS on television. The other 25% stated that they either did not have television or did not have time to watch it. Most reported that they only caught snatches of programs. One participant when talking about AIDS programs said: " And I don't really pay attention to them either." (BF) Many could not recall exactly what programs they had seen and explained what they had learned from the programs in very general terms such as it talked about how you could get the disease. What did seem to have made an impression on most adults was the pain and suffering caused by the disease.

Reactions to the AIDS commercials varied from those who thought the commercials didn't tell enough to those who thought the commercials got the message across that AIDS was something that anyone could get if precautions were not taken. The following are examples of responses to the question asking what they learned from the AIDS commercials:

> Oh, not really anything, just ah . . . to do something about it. It doesn't tell you what to do. (CF)
>
> They're all hidden, you know, and they don't come right out . . You know, if that was there, if some--if they just come right out in how that happened, how that started, then maybe I'd fear of it. But this way, you know, they just don't say much. Well, they don't even show or anything, you know--nothing. (CF)

> Precaution. That it's out there and . . I think basically that's the message I get from them. (BF)
>
> It gives you a clear message. That it's so easy to get--anyone can get it. (BF)
>
> I think they really get to people. It makes them stop and think. (AF)

The soap operas appeared to have given some adults an idea of the affect of AIDS on a person's life: "I'm glad they do [show as AIDS victim on a soap], it gives those people like myself that don't really want to read the magazines or listen to the other talk shows about it, they get to learn a little bit about the personal life of the AIDS victim."(AF) but the limitations of using this as an educational method is noted in the following comments: "You get a better picture of it. But I don't even know what half of what AIDS is. There's so many questions not answered."(AF) and "Some of them might be true and some of them may not be because they just wanted to put on the videos."(CM)

Magazines and Books. The women were specifically asked if they had read articles about AIDS in magazines. Of those who had, the magazines that they recalled reading AIDS articles in were Chatelaine, Time, and Macleans. Due to an oversight, the men were not specifically asked this question and none offered this as a source of AIDS information.

No one had seen or read a book on AIDS. A couple of reason given for this were: "I didn't even know they had them."(AF), and "I don't really go around looking for books and stuff like that."(AM)

Pamphlets on AIDS. By far, more women than men had read pamphlets on AIDS. One reason for this could be that 50% of the men had never seen an AIDS pamphlet while only 20% of the women were in that position. Like other methods of learning, the usefulness of the pamphlets varied among the adults. Some examples of the reactions to the AIDS pamphlets were:

> Well, kind of complicated. Yeah, it's more hidden stuff. I had to figure out. (CF)
>
> I can understand it. But, I understood more from TV, though. (CF)
>
> I had picked some up and I didn't even bother reading it--just a little bit of it--and I put it away. (BF)
>
> [Daughter] brought a lot of pamphlets from school, but I don't think anyone ever opened them to read them. (CF)
>
> My kids brought some home--little pamphlets with not much information in it. (BF)
>
> Yeah, they [AIDS pamphlets] were good to read. Good to know something about it. (AF)

Direct Sources of AIDS Information

The three adults who said they had attended an AIDS information session did so as part of their Alberta Vocational College (AVC) upgrading program offered in the community. The information was provided by the community health nurse. One adult explained what she had learned:

> How you get AIDS and . . . and like is it contagious--you know, all these questions, like can you get it from a toilet bowl and all of this. And we actually saw a video on a few patients that had AIDS and how they got it and like what happened to them, what they went through . . . and all that. It was good, actually, but then you feel pretty terrible afterwards. (AF)

Preferred Learning Strategies

The preferred educational learning strategies have been broken down into methods and techniques. Each of these areas contribute to the description of how the Metis adults prefer to learn health information. In addition, the adults have described ways they feel these strategies would work best in their community.

Methods

Quite a variety of ways of informing community members about health risks were suggested by the participants. These have been summarized in Table 5.14. Multiple responses were given which reflects the participants' view that several ways should be used concurrently. The participants had varying views on who should make decisions about providing health information in the community. The women were almost evenly divided on the question of who should make decisions about providing health information in the community. Half felt that the people should decide while the others thought the health unit and in particular the community health nurse should be making the decisions as to what health information was needed in the community. A couple of women did suggest that the health unit along with council should make decisions. The responses of the men, on the other hand, were fairly equally divided among the following decision makers: the people, the health experts, the health unit and the community council together, and a health committee.

Table 5.14

Reported Ways of Informing the Settlement Members about Health Risks*

Ways	Males 18-30 (n=6) %	Males 31-45 (n=6) %	Males 46+ (n=5) %	Females 18-30 (n=11) %	Females 31-45 (n=9) %	Females 46+ (n=4) %
Informal - Word of Mouth	17	0	20	0	0	25
Workshops	67	17	0	55	33	75
Home visits/phone calls	50	50	20	9	22	25
Posters	0	0	20	18	0	0
Pamphlets	17	33	0	9	0	0
Videos to borrow	0	33	20	9	0	0
Books to borrow	33	17	0	9	11	0
Community newsletter	33	33	0	18	0	0
TV/radio	33	17	0	0	11	0
Letters home with students	17	17	0	0	0	0
General meeting	0	17	0	9	33	25
Provide information to existing groups	0	0	0	9	0	0
Survey people for desired ways	0	0	0	0	22	0
Inform school students first	0	0	0	18	22	0
Outside information phone number	17	0	0	9	11	0

Note. The values represent percentages of response frequency within each gender-age group.
* multiple responses were allowed.

More specific data was obtained regarding preferences for two approaches: one to one and workshops. These can be found in Table 5.15.

Table 5.15

Reported Preference of Educational Method by Gender and Age Category

Method	Males 18-30 (n=6) %	Males 31-45 (n=6) %	Males 46+ (n=7) %	Females 18-30 (n=11) %	Females 31-45 (n=9) %	Females 46+ (n=4) %
One-to-One	0	33	0	9	0	25
One-to-One & Workshops	17	17	17	27	22	0
Workshops:	67	34	72	54	77	75
Mixed	50	0	43	9	44	50
Separate - male & female	0	17	29	9	0	25
- adults & youth	0	0	0	9	0	0
No preference	17	17	0	27	33	0

Note. The values represent percentages of response frequency within each gender-age group.

One-to-One. Only a few adults said they would prefer to learn in a one to one situation. Reasons given for this preference were shyness, being more comfortable in a one to one situation, and enjoying a greater amount of exchange between the information provider and the individual. One male said that although this was the way he would prefer to learn, due to lack of time, workshops were a better source of information.

One-to-One and Workshops. Some adults, while preferring a one-to-one approach, saw benefits to offering workshops: "One-to-one preferably but a workshop will be fine. Because there's more people to ask different questions and they can learn something you didn't think of."(AF). Others liked both methods and often gave reasons to justify having a workshop, for example,

> I like to go to a workshop and I like talking one-to-one too. But probably a workshop would work better, there's a lot of fear about talking about AIDS even in a public place but I'm sure that if there are a few people there who have input it will relax other people and they'd talk more and be more apt to listen. (AF)

> Both one to one and workshop would be good, because in a workshop if you don't want to ask a question there is always someone with the same question. (AF)

Adults differed on which method should be used first. For instance, one adult thought the one-to-one approach should be used first:

> Like I told you earlier, I think one-to-one would be the best way to start off. And then this way . . . people would be--I think people would feel a little bit more comfortable if they come in small group sessions, and possibly have a workshop. (BF)

Meanwhile others thought one-to-one follow-up after the workshop should be available:

> I don't know, I think it'd probably be a combination. Because a lot of times in the group discussion, other people will bring up things that haven't occurred to you. And it may be there in your mind but you just somehow haven't brought them forward. And a lot of times some other people will have a lot more courage in asking the kind of questions that . . or getting the kind of answers you'd like to get. . . . . 'Cause a lot of times people have to think things over, and sort of discuss things, and they find that they need a few more answers, and . . .(BF)

> Yeah, a combination of it. And then like having a place--access to a place where you can go and sit down and talk with somebody, or read or watch videos or whatever. (AM)

Workshops

Why workshops? There were a variety of reasons given for why workshops were seen as the preferred way of learning about AIDS. A few examples are:

> A workshop would be good because a lot of people enjoy workshops. (AF)

> There are also people who don't read, I guess it would be good if they do have workshops too, so they would know. (AF)

> . . and being in a workshop, other people ask questions that never, never come to your mind. Or have known--some people have a very direct way of asking, a very straightforward way of asking, where if I'd have to ask that question, you know, I'd probably get it upside down or ignored it. And by listening to people talk about something, you learn more than you actually-- (CM)

Many of the adults also mentioned that they preferred to have information be presented to small groups or if presented to a large group that there be an opportunity to break up into small discussion groups.

Despite this preference for workshops, many felt that attendance at a workshop would be poor as illustrated in these responses: "Probably a workshop but I don't think anybody'd go to them."(BM), and "Well, I like this idea of having the workshops and that, but then a lot of people don't go to them, either. "(BF) There were several references though to the fact that even if the turnout was not great, the information would get to the people:

> Invite the whole community and whoever shows up . . . work on them. Then they can go out and spread the information, as long as if you know and find out information about it, then they could--you know, they could by word of mouth. (BF)
>
> To have . . . say a workshop meeting for, I don't know, you wouldn't be able to get everyone there but I'm sure you'd get the most interested--to go to the workshop meeting, sure they'll listen, see films, have some good guest speakers and then from there, people that do go to the meeting can pass it on to friends and young ones just to let everyone know that there is another disease out and mainly to pass it on." (AM)

Motivation to attend. Some suggestions for getting more people to attend the workshop were made. These included the suggestion to offer the workshop to an existing group, for example,

> It's hard to get them out, but working through--like maybe a ladies' club or something would help. (BF)
>
> I know workshops don't work very well. Maybe they'll draw a few people but . . . Maybe you can have a program of some kind once a week or something and you deal with different things. Or maybe if there was some kind of program going on . . . maybe the health unit could come in and set up maybe an hour of some kind of program, while these people are there they can pick up something. (AF)

One suggestion implied that people would attend in response to fear-- "I think they would [attend an AIDS workshop]. Especially if there were a few people that had an idea that was in the community. I think they would."(BF), while another was that attendance depended on the personal contact, phoning or visiting the people to explain the purpose of the workshop and to individually invite them to come. It was also recommended that the workshop be tried a couple of times allowing individuals to give feedback on what they would prefer the next time. Additional suggestions were to advertise the workshop everywhere so you couldn't possibly ignore it, and providing incentives such as paying a dollar to each person attending the workshop, having a door prize, or having a community supper along with the workshop. One male summed it up by saying, "It has to be an attraction, then everybody will come." (AM)

Mixed versus separate. Although most people did not say why they would prefer to have the AIDS workshop mixed, that is both men and women, several adults gave these explanations for their position:

> They should be together because they . . . they blame the woman. And the woman blames the man for such a thing. (BF)
>
> I think it should be mixed. Because something that the men don't understand, the woman can say; and what the women can't understand, the men can say. (CF)
>
> It takes two to tango so you might as well learn about it together. (AM)
>
> . . . if you're together you're serious, eh. (AM)

Like those who preferred the one-to-one approach, to feel more comfortable and shyness were given as reasons for preferring separate workshops for men and women. Those who gave shyness as a reason, said that the use of a question box would eliminate their concern about a mixed workshop. The next two responses show that many feel once the workshop gets going, people will forget their shyness:

> Some might [be too shy], but once you get going, it would be no problem. (CM)
>
> As long as that one person starts, then I don't think there'd be any problems. (BF)

Who should provide the information about AIDS? The response given by about half the women in each age category was that the health unit should be the one to lead the workshop. The next most frequent response made by the women was that the individual's knowledge of the subject and communication skills should decide who provides the AIDS information. Individual characteristics was also the most frequent response made by the youngest and oldest men, with the next highest response rate indicating that the men in the youngest and middle age groups thought the health unit should teach about AIDS. The majority of those who indicated that the health unit should be responsible for providing the AIDS information went on to name the community health nurse as the appropriate person for the job.

As for who would be seen as being the most credible to the people, the majority of men and women said it would be someone from the medical profession. Having an AIDS' victim at the workshop was also seen by a few as being effective in getting information across to the people. About twice as many adults thought that the person providing the AIDS information should be from outside the community than those who felt that it didn't matter where the person was from as long as they had a good knowledge of the disease. Several thought that if the person presenting the information was from too far away they would either not understand the people and their situation ("I kind of think maybe a local area, like someone from the health unit probably would be acceptable because another argument I've heard is, how the heck do they know, they don't live around here." (BF)) or not be able to provide any follow-up ("It would be to have one from here--it would be better 'cause . . . that person would be available in the community if somebody wants to learn more about AIDS."(CM))

A few offered solutions similar to this, "Maybe a combination of the health unit and someone from --something like that, like . . . it would carry a lot of--it might carry--I think it would carry a lot of credibility." (BF)

When to have a workshop?

1) time of day-- The majority said that the evening would be best although there were a few who said they might not be able to attend in the evening because they work shifts.

2) day of the week-- Monday and Tuesday evenings were reported to be the best. Events to consider when planning a workshop are Wednesday evening prayer meetings, Thursday and Friday late night shopping, and bingo which can be played nearby every night of the week.

3) time of the year-- Winter, that is between November and March, was seen by most to be the best time of the year for a workshop. Reasons given for this were that it was the quiet time of the year, the weather restricted the amount of traveling the people did, and generally people look for something to do during the cold months. Spring and fall were the next choices, but summer was definitely out.

Techniques

Participants were asked to discuss their preferences about five educational techniques:

1) Videos. Comments made after viewing three AIDS videos describe what the Metis adults would like to see in an AIDS video, which are:
   - (a) Facts about the disease presented in a clear straightforward and simple manner.
   - (b) Details are provided, not just superficial statements.
   - (c) Real people should be used not symbols because they are:
     - i. more eye-catching,
     - ii. more 'real' (symbols give the feeling of fantasy) "To have people in there would be more realistic."(BF)
     - iii. more serious, for example, "to me it's something about the cartoon-like people it just doesn't seem serious enough."(BF) and one male made a joke out of the female symbol being upside-down by asking if the cross meant they were goners!
   - (d) Medical professional who are experts in the field providing the information.
   - (e) Terms which might possibly be difficult to understand such as medical ones, are simply explained not excluded .
   - (f) Information presented informally to a group of adults.
   - (g) Information presented followed by a question and answer period.
   - (h) An AIDS victim to describe how the disease has affected his/her life.

Specific comments about three video clips viewed illustrate some of the preferences listed above:

AIDS: The New Epidemic. This video made by the Centre of Disease Control in British Columbia was chosen by the majority of the adults to be the best. They liked having a doctor being "honest about it "[the situation with AIDS] and in a very "down to earth" fashion describing "the whole system of how you can get it and how you can't get it." This video was felt to be appropriate to show to both adults and youth in their community.

AIDS Alert. The AIDS Alerts video was not well liked by most adults as it did not provide enough information. Several did suggest it could be useful in certain circumstances, for instance, to start off a program, "Cause it's more, you know, gradually going into it."(AF), for use with older people because "it's simple. Like it's something that they could understand. It's not too in detail, like all these big words that the old people won't understand."(BF) and with the younger teenagers "because it's based around comical things."(AF)

AIDS: An Epidemic. This was a video of a US TV show that provides AIDS information through the discussion of results from a US AIDS Knowledge poll. This video ranked the least popular among the adults. Some comments were that is contained a lot of talking, you'd really have to be interested in order to learn from it, and the true-false questions were childish and reminded them of school.

2) Stories. The Metis adults felt that a story illustrating how the AIDS disease could come into their community made the situation surrounding the disease much more understandable and real. Some comments reflecting this are:

> The story hit close to home. Real believable, that it could happen in a place like here. (AM)
>
> They make a person think. (CF)
>
> That's really something to think about , you know? Cause there is a lot of people that will try something just once, you know, and . . . you know, just on impulse or whatever. (AF)

Two people had some reservations about using a story. One thought that it might be hard to hold people's attention, "If you're really listening, I think it would benefit."(AF03) and a second simply stated his preference, "I'd rather learn from a professional, like the TV. Doctors, etc." (BM)

When asked if one of the traditional ways of learning, specifically that of grandparents and elders teaching children though story-telling was continuing today, the reply was that it was not happening very much. Two reasons were given for this change: one, "If a person has the time, I guess, to sit and listen to what other people say but nowadays life goes, you know--Most of them [children] have things to do that you don't have really the time to sit and listen." (BF), and "There's not very many old people left." (AF)

3) Demonstration of the proper use of a condom. The initial reaction to this demonstration was one of questioning what the purpose of the demonstration was, but after seeing it most agreed that it would be useful to include a condom demonstration in a workshop. Some gave general reasons for the demonstration's usefulness, "Cause I'm sure a lot of people never know how to use it."(BM) and "Well if it's really necessary for your health--it's pretty scary."(AM); while others saw it being especially helpful for parents, "They're going to have daughters and sons that are going to need--or they're going to have to talk to them about it, and they're going to know at least something about . . ."(AF)

Although the majority of adults were not upset by the demonstration, some were uneasy as this statement illustrates: "It doesn't bother me, it's just kind of embarrassing." (BF) A couple of women felt it would be less embarrassing to see the condom demonstration on video, but most thought when it was done live they would learn more because a live demonstration was more personal and allowed the people to really see and touch a condom.

Several stated that they had learned something new, for example that oil-based lubricants can cause condom deterioration and that air left inside the condom may cause it to break during use. In addition, two concerns were raised: one to do with the morals that would be promoted in doing the demonstration and the second was " how easy is it going to be for a parent to go home and show their teenagers what . . . now, this is what you do, and this is what you don't do"(BF).

Many of the adults found it amusing that condoms were handed out so that they could actually practice the proper use of the condom by rolling it onto their own fingers after the demonstration. Many did not open the package. When asked what they thought about being given a condom , one female replied,

> I think like giving us one, it'd be easier. Touch it and handle it--like you know, like . . . not be leery of it more or less, like that's the kind of thought I had with these. Geez, I didn't really know if I should touch it or take it. (AF)

Most adults felt that there was sufficient access to condoms as they were available at a local service station as well as in the nearby towns. A couple of adults did comment on the expense of condoms and questioned if the guys would actually purchase condoms even though they were available, especially if they had to ask for them.

One adult explained why she thought condoms were necessary for the youth in the community:

> Because a lot of people today, their Christian faith is not that strong as it used to be in the old days. Today they go to church and pray a little bit, but once they get out of the church and they're out in the world, and they do whatever they--you know, whatever comes to mind. They drink and they have sex and all this kind of thing. It's not as--like it used to be in my days, you know. That's why they need something like this [condom demonstration], is their beliefs are a lot different. (CF)

4) Pamphlets

a) General Usefulness of Health Pamphlets

Useful. The majority of adults felt that health information pamphlets are useful. Some reasons given for this position were that pamphlets are easy to pick up, easy to read, get right to the point,and free; they can be read privately; they are a good pastime when waiting in such places as doctors' offices; and they can act as a door-opener by informing the reader where further information can be obtained.

Not useful. Being too shy to take pamphlets, being frustrated that after reading pamphlets one always has questions that if one can't find someone to answer them--you just have to forget about them, and the fact the there are just too many pamphlets about nowadays to be bothered were explanations given by the few adults who do not feel pamphlets are useful in providing health information.

b) AIDS Pamphlets

Comments made after reviewing several AIDS pamphlets can be used to describe the features that Metis adults see as important in an AIDS pamphlet. These features are: bright and eye catching; provide the facts but not too much writing; provide answers that are straight, short and to the point; organized from what the disease is to treatment and then protection; and provides answers to the questions that anybody would have in their mind.

Many liked the question and answer format although one person specifically disliked the true and false approach as it reminded her of school. In addition, there were several comments such as, "I think the more you can . . 'cause not everybody's the same, eh? Some people might be interested in . . . do more reading, some people less." (CM) which indicated the benefits of having a variety of pamphlets.

Both men and women reported that they had picked up AIDS pamphlets in doctors' offices. Men went on to say that these pamphlets had also been found in the hospital, at the Alberta Alcohol and Drug Abuse Commission (AADAC) office and at AVC Upgrading class. Women, in addition to finding them in the same places mentioned by the men, had also picked them up in the health unit and had seen pamphlets that their children had brought home from school. When asked if there were other places where AIDS pamphlets should be found the many responses were similar to this: "wherever there's people hanging around."(CM) More specific answers mentioned the settlement administration office, the church, and the school.

Of the specific pamphlets reviewed by the participants the one called, "AIDS: The New Facts of Life" was the most preferred, with "AIDS-What Everyone Should Know" coming in second.

5) Books. Generally the adults felt that it would be good to have a few books on AIDS and other health topics available within the community to borrow. In contrast, one adult expressed her doubt that books on AIDS would be that useful with this comment, "But with books like these I think the person would have to be interested themselves and find out information before they'd go and look for it."(BF)

A couple of other opinions about the usefulness of a community access to health resource books were: "Well, I think most people would [borrow the health books]. "Cause I mean, if you're going to find out something, you got to have a place to start."(CM) and "It [access to health books] would be nice, but then like I say, how many of them would take time out to read them?"(CM)

As there is presently no community library, the question of where to keep health resource materials was met with several suggestions which included the settlement administration office, the health unit office, the school and the AVC library. It was also suggested that there should be some evening access to the resource books and that the availability of these books could be advertised through posters and sending notes home from school.

In addition to health books, several adults thought that it would be useful to have access to health-related videos.

Summary of Preferred Learning Strategies

1. A variety of approaches should be used to inform the community about AIDS such as workshops, posters, personal contact, the community newsletter, and general meetings.
2. Workshops are seen as preferred way to present health information.
3. One-to-one information could be used both to convince people that they should attend the AIDS workshop and to provide follow-up information after the workshop.
4. Workshops should be mixed, both men and women.
5. Information at the workshop should be presented by an individual who is knowledgeable about AIDS and has good communication skills. Community health nurses are seen as qualified to lead workshops.
6. The best time for a workshop would be a Monday or Tuesday evening between beginning of November and the end of March.
7. Group discussions are seen as a preferred method of becoming familiar with new health information.
8. AIDS videos should have a medical expert provide the facts in a clear, straight forward manner to a group of adults.
9. A demonstration of the proper use of condom should be done at the workshop as well as handing out condoms for workshop participants to practice with.
10. Stories that explain how the disease can affect their community should be used and discussed.
11. A variety of AIDS pamphlets should be available within the community at such places as the health unit, the settlement administration office, the church, and the school.

12. The community should have a few books and videos on AIDS available for settlement members to borrow.

CHAPTER 6

NEED ASSESSMENT

Need assessment is the process of estimating the relative importance of identified needs (Siegel, Attkisson, & Carson, 1978). As with the need identification, the AIDS Educational Model was used to guide this process. The AIDS Educational Model (Figure 2.1) suggests that the needs identified in Chapter 5 should be assessed, interpreted, and prioritized according to their influence on an individual's probability of practicing risk free behaviors associated with AIDS.

Whether a particular factor is viewed as a benefit or barrier to the practice of AIDS risk free behaviors depends on the program planner's interpretation of the data. This interpretation is influenced by the program planner's conceptualization of health as well as other values, expectations, and assumptions that have been derived from past experiences and the review of the relevant literature. More specifically, the assessment of need is the result of reviewing how the data function in the model. In order to discover what factors appear to influence the different group responses and how these responses affect individuals' perception of the benefits and barriers to practicing AIDS risk free behaviors, identified needs are contrasted to both what the literature suggests facilitates the practice of AIDS risk free behaviors and to data obtained from different groups (Figure 4.1). The program planner would also investigate the relationships between the target audience's personal characteristics and the desired outcomes.

Throughout this study, needs have been identified from both emic and etic perspectives. The emic perspective was achieved by directly asking the Metis adults what they wanted to know about AIDS and how they would like to learn this information. Using the AIDS Educational Model to guide the investigation of factors that influence the desired outcomes, permitted needs to be identified from the etic perspective. Identifying needs from both perspectives allows for a more complete and accurate picture of the needs. This picture is further enhanced through the use of both quantitative and qualitative approaches. The quantitative approach provided a quick means of assessing need and allowed for the comparison of findings between the various groups. Meanwhile, the qualitative approach both verified the quantitative findings and provided richness to the data by identifying unique factors that influence the practice of AIDS risk free behavior in the Metis adults.

The key findings will be discussed in terms of how they might influence the probability of behavioral change and how an AIDS education program can build on these factors to enhance behavior change. The researcher's background in community health nursing as well as her previous experience working with Metis populations was used, along with the following criteria, to assess the AIDS educational needs of the Metis adults:

1. the potential of the finding, according to the AIDS Educational Model, of being a barrier or enhancer (benefit) to the practice of AIDS risk free behaviors. By identifying these, the program planner could promote the perceived benefits and look for ways of reducing the barriers.

2. the consistency of the findings within the group. The within group comparisons were used to look for differences that might result in a finding being perceived as more of a barrier or a benefit to a particular gender or age group. These differences may suggest using different approaches with the subgroups.

3. the consistency of findings in comparison to an outside group. As there are no available norms for the attitude scales it was necessary to use a comparison group as a benchmark. The comparison group used, consisted of 116 adults (24 males and 92 females) attending an undergraduate Human Sexuality course at the University of Alberta in 1988. Eighty-eight percent of the University adult sample were between the ages of

18-30 years ; 9% were between the ages of 31-40 years; and the remaining 3% were above 41 years of age. The University adults described themselves as being relatively well informed about AIDS; their main sources of AIDS information being books, pamphlets, and newspapers. Attitude change or motivation to change behavior was identified as the students' main need with regards to AIDS education.

4. the consistency of the findings to the literature. The literature contributed by indicating what factors are seen in the general adult population as benefits or barriers to practicing AIDS risk free behaviors.

Using these criteria, the salient needs were determined from the factors reported in Chapter 5. Prioritization of needs in this study refers to the selecting of key factors that must be addressed to achieve effective AIDS education and not to the ranking of needs.

Perceptions of AIDS

The AIDS Educational Model indicates that perceptions of the disease, and in particular how individuals perceive the seriousness of AIDS and their chance of contracting AIDS as playing a major role in predicting how individuals will behave in response to the disease. For action to be taken, individuals have to feel that they can contract the disease and that the consequences of getting the disease warrant taking action. They also have to believe that they are capable of taking the required action, that is, that they have the necessary knowledge and skills to practice AIDS risk free behaviors. In addition, individuals must believe that if the action is taken, it will be worthwhile. A review of the results shows that the Metis adults should be receptive to the practice of AIDS risk free behaviors.

Metis adults saw AIDS as a serious and fatal disease and one that could be contracted by someone in their community. Eighty-five percent of the men and 52% of the women felt that it was possible for them to personally get AIDS. In addition, scores on the Fear of AIDS Scale indicated that the Metis adults felt moderately threatened by the disease.

Although not significantly different, it is interesting to note that males felt more threatened by the disease than did females, and that for both males and females, the level of fear or threat of the disease was greatest among the oldest age category, followed by the youngest; with the least fear being expressed by the middle age category.

In an effort to investigate what effect scores on the Fear of AIDS scale might have on probability of practicing AIDS risk free behaviors, the scores obtained by the Metis adults were compared to the University adult sample. The results of the comparison indicated that scores were significantly different in that the Metis adults were more fearful of AIDS than adults in the University sample (Appendix B, Table B.1) and that the different level of fear was due to the group differences, not gender differences. Although it is not surprising that the difference is due to group effect, it is somewhat unexpected to find that the predominantly younger University sample who are probably at greater risk of contacting AIDS due to their developmental stage, felt less threat of the disease than the Metis adults who were older and generally in stable relationships. Group differences that could possibly account for the different levels of fear would be the University sample's greater knowledge of the disease and higher education level. The same factors may also account for the highest level of fear within the Metis sample being reported for the males in the 46+ years group who have the lowest educational level and knowledge of AIDS. Indeed, other research studies have also noted the inverse relationship between threat of AIDS and level of knowledge (Worber, 1988).

Although fear, or threat of the disease is seen as a component that contributes to the probability of behavior change, the literature is not clear on what level of fear or threat is conducive to the practicing of risk free behaviors associated with AIDS. Educational programs may increase fear or threat of the disease by making people aware that it exists and that the individual is at risk of contracting it, or it may decrease these feelings as the program clarifies which behaviors spread the disease and the steps one can take to reduce contact with the disease. Some researchers (Antonovsky & Hartman, 1974; Edgar, Freimuth, & Hammond, 1988) have noted a curvilinear effect that fear or threat of the disease has on behavior. Where it is very high or very low, little behavior change is noted. Moderate levels of fear or threat appear to have the most positive effect on the practice of desired behaviors.

Another aspect of the individuals' perception of AIDS which might influence the probability of practicing AIDS risk free behaviors is their general attitude towards the disease. Scores on the AIDS Attitude Scale indicated that generally the Metis adults had an attitude towards the disease that would appear to be congruent with the practice of AIDS risk free behaviors. The actual probability of these adults practicing risk free AIDS behaviors however has not been assessed. Attitude scale scores can only be used as a potential indicator of how an adult might respond. For instance, the fact that mean scores for both the entire AIDS Attitude Scale and the subscale measuring the individual's belief about taking action to prevent the spread of AIDS were significantly lower for adults in the oldest age category than adults in the youngest age category, cannot be interpreted as proof that adults in the oldest age category would be less likely to actually practice AIDS risk free behaviors. These results by themselves may not be important. Other factors must be considered such as the fact that the adults in the oldest age category are probably at less risk of contracting AIDS or that their views of safe sex practices may be more conservative. This example shows the importance of putting the findings back into the context of the model and not losing sight of the many determinants of a person's behavior.

Despite the Metis adults overall positive attitude towards the practice of AIDS risk free behavior, responses to several scale items indicated areas that should be addressed by a program planner because of their influence on the probability of practicing AIDS risk free behaviors. For example, about 40% of the Metis adults believed that no matter what they did, if they were going to get AIDS, it would happen and about 18% felt that practicing safe sex methods to prevent AIDS wasn't worth the effort. Why these attitudes were expressed may again reflect lack of knowledge about the disease or perhaps a feeling that they personally wouldn't be in contact with the disease and therefore could do nothing to control its spread. Whatever the reason, it is important for an AIDS educational program to address the issue of how the spread of the disease can be controlled by individuals, not only by changing their own behaviors but also by encouraging others to practice AIDS risk free behaviors and changing society so that these behaviors become the accepted norms.

To further illustrate how scores on the AIDS Attitude Scale might relate to the practice of AIDS risk free behaviors, the mean scores of the Metis adult sample were compared to those obtained by the University adult sample. Two-way analyses of variance by gender and sample (Appendix B, Table B.1) showed for the entire AIDS Attitude Scale and all its subscales, that group differences accounted for the University adults' significantly more positive attitude towards the practicing of AIDS risk free behaviors than the AIDS attitudes held by the Metis adults. In addition, for the subscales of motivation for education, and disbelief, gender also contributed to the difference between the two samples. In both samples the females scored higher than the males.

The fact that the University adults scored higher than the Metis adults on the AIDS Attitude Scale but still reported a need for AIDS education in the area of attitude change or motivation to change behavior is significant. The indication of need for education in these areas by the University adults may have reflected their awareness that even though they knew the behaviors that will reduce their risk of contracting AIDS, they were having difficulty putting these behaviors into practice. Therefore it is reasonable to assume that the Metis adults who scored significantly lower on the AIDS Attitude Scale would also have difficulty putting knowledge into practice and require educational programs to address the areas of attitude change and motivation. Furthermore, the sample comparisons clearly indicated that personal characteristics of the group influence an individual's attitude towards AIDS, and must be considered when planning an AIDS educational program.

Two questions in the AIDS Attitude Scale may have affected the scale scores depending on how they were interpreted by the respondent. In both "I would practice safe sex methods when sexually active." and "Practicing safe sex methods isn't worth the effort.", the term "safe sex methods" was not defined. Thus it was possible that respondents only interpreted safe sex methods as using condoms and not as also including maintaining a mutually faithful relationship with one partner. If they were in mutually faithful relationships with one partner, but didn't see this as a safe sex method, they may have responded negatively to the two statements. This interpretation of safe sex might have lowered the score for the Metis adults of whom 70% were reported to be married or in stable relationships and may not have seen a need to use condoms. Unfortunately the University sample was not asked for marital status so no comparison could be made as to how this might have influenced the responses.

Health Attitudes

The AIDS Educational Model shows health attitudes as being among the many factors that modify or influence perceptions of AIDS. Comparing the health attitudes of the Metis adults to the University sample (Appendix B, Table B.1) by group and gender, indicated significant differences in attitudes due to group effect. Regarding health attitudes, the Metis adults had a more holistic view of health (Health scale mean score of 18.5) and greater belief in the interaction between health and behavior than did the University sample (Health scale mean score of 15.1). Because the reliability for the Health scale (.67) was lower than for the AIDS (.81) or Sexuality (.70) scales results of the Health scale should be viewed with caution. However, the Metis adults' health attitudes as indicated by the scale scores were validated by data from the content analysis.

During the interviews, health was often referred to in holistic terms and spirituality was identified as playing an important role in maintaining the health of Metis adults through either direct influence from the church or through one's faith in the Lord. One hundred percent of the men and 72% of the women reported that lifestyle activities or behaviors affected their health. Knowing that the Metis adults recognize that lifestyle activities affect their health would facilitate the inclusion of lifestyle behaviors that reduce the risk of contracting AIDS into their health beliefs. Also the adults, especially in the oldest age category, mentioned how important health was to them; a belief that would increase the probability of an individual making changes to maintain their health.

An aspect of the Metis adults' health attitudes that plays an important role in evaluating the probability of behavior change is their belief about making changes in health behaviors. While the majority of adults said they would change health behaviors if they found out that these behaviors would make them sick, 75% of the men and 44% of the women said that they would have to experience some adverse effect before doing so. At the present time, with there being no cure for AIDS, waiting until one experiences an effect has drastic, if not fatal, consequences. Only 15% of the Metis adults reported that they would change a health behavior in response to knowledge of serious consequences. Reasons given for the lack of response to knowledge of serious consequences of health behaviors were that they knew people who engaged in behaviors known to have serious consequences who had not suffered any serious consequence so why be concerned, that habits such as smoking were hard to break, and that they distrusted written information. Where there had been exposure to negative consequences of health behavior change had taken place. To decrease the barrier effect of this belief, the program planner could try several things: one, information about safe sex methods could be introduced before individuals have developed sexual habits; two, AIDS victims could be asked to explain how they became infected by people who showed no symptoms of being sick; and three, adults could be informed about reliable sources of health information.

Sexuality Attitudes

Sexuality attitudes also modify perceptions of AIDS, specifically with regards to the sexual transmission of the disease. The majority of the Metis adults grew up in homes where sex was a taboo subject and frequently referred to as sinful and dirty. Although they now saw the subject of sex as being more open, feeling comfortable discussing the topic varied greatly among the adults. The majority of Metis adults felt that sex education should begin in the home but suggested that few parents were actually doing this. The main reason given for adults not discussing sex with their children was the lack of knowledge and skills needed to accomplish the task.

The scores on the Sexuality Attitude Scale indicated that the Metis adults had attitudes that would tend to act more as benefits than barriers to the practice of sexual behaviors that reduce the risk of contracting AIDS. However, there were some significant differences among the group. First, females had sexuality attitudes that were significantly more positive towards discussing sexual issues and practicing "safe sex" behaviors than the males. And second, adults in the youngest age group had a stronger belief in taking responsibility to prevent sexual disease than did adults in the oldest age category.

Comparing the sexuality attitudes of the Metis adults' to those of the University adult sample showed that the attitudes held by the Metis adults were significantly less positive than the sexuality attitudes of the University adults. More specifically, the adults in the University sample reported significantly greater agreement with the beliefs that individuals are responsible for preventing sexual disease, and that sex can be talked about, than did the Metis adults. Analyses of variance also showed that the females in both groups had significantly more positive attitudes towards sex in general as well as towards the individual's responsibility for preventing sexual disease and discussing sex openly.

This data suggests that Metis adults might benefit by receiving information about sex. As most adults learned about sex through trial and error, and from older siblings and peers, some of their discomfort with talking about the subject may stem from lack of knowledge. It is also possible that the males' less positive attitude towards sex is the result of misinformation. Over the last few years females have had more health and sexuality information targeted towards them both through school programs about menstruation and in magazines which may have influenced their more positive sexuality attitudes.

Knowledge of AIDS

The knowledge of a disease is seen in the literature as an important indicator of behavior and often as a prerequisite for behavior change. Although increasing the knowledge of AIDS does not always result in the practice of AIDS risk free behavior (Edgar, Freimuth, & Hammond, 1988; Siegel & Gibson, Worber, 1988), it is a consistently important variable (Emmons, Joseph, Kessler, Wortman, Montgomery, Ostrow, 1986). Often other factors interfere with the response one would expect as a result of knowledge about the disease. The AIDS Educational Model shows how interference might occur by placing knowledge as a modifier, not as a direct influence on the probability of behavior change.

The Metis adults expressed a need for more information about AIDS, its causes, its symptoms, and how to prevent its spread. Their knowledge of AIDS was similar to that reported for the general adult population whose main source of information had been the mass media. The majority of Metis adults knew the main routes of disease transmission and recognized the major risk behaviors associated with AIDS but were confused about specifics such as the transmission of the disease through the giving of blood and via insect bites. Lack of knowledge about the disease was more noticeable in the older adults, especially in the male 46+ years group.

Two comments should be made about the method used to test AIDS knowledge. First, a forced answer questionnaire was employed. While this method ensured that adults had to take a stand and not just opt out by saying they were unsure, it also forced adults to guess at questions they did not know. This might explain why 100% of the females in the 46+ years group agreed with the statement "Illegal needle drug users are more likely to get the AIDS virus." while at the same time, 40% of them also agreed with " AIDS in only passed through sexual contact." Second, several questions were poorly worded, making it possible for either yes or no to be the correct response depending on how technical one decides to be. For example, technically AIDS refers to the full blown disease but because the general public uses the word AIDS as synonymous with HIV infection, this study established true (yes) as the correct response for "AIDS is caused by a virus." and "A blood test tells if you have AIDS."

Comparing the knowledge responses of the Metis adults to those of the University sample (Appendix B, Table B.2) showed the results one would expect in that the University adults, especially those in a sexuality class, had more accurate knowledge of AIDS. Although not tested for significance, it is interesting to note that a greater percentage of the Metis adults as compared to the adults in the University sample were aware that AIDS is not spread through needles used for medical purposes, and that people who use drugs or alcohol are more likely to get AIDS. The response to the question about the effect of drug or alcohol use on the likelihood of contracting AIDS must be viewed cautiously as the question involves two factors and thus is difficult to assess.

Despite their knowledge that AIDS is a fatal disease and their acknowledgment that there was a possibility that they could personally get AIDS, the Metis adults' main concern was for the well-being of their children and youth in general. In fact, because the adults saw the children's risk of contracting AIDS as greater than their own, they also stated that children should have the opportunity to learn about AIDS before the adults. One female described the Metis adults' concern and what should be done about it:

> They'd be crazy if they didn't [ask questions about AIDS], if they weren't concerned. Because they all have children, and that's a possibility that . . . the way sex is so free these days that people should definitely learn more about AIDS and what damage it can bring them. I would strongly suggest that something like that [an AIDS workshop] be done. (CF)

In addition to learning more about AIDS in order to protect their children, the adults felt that AIDS should be taught in school, "I think that would be a good place for them to learn. They'd get more of the facts there than from parents. I don't think that many parents would know about . . . until they go to different things." (AF) Teaching about AIDS in school was seen, not only, as a way to educate the children about the disease, but also as a way for parents to learn:

> Like start talking about it in the schools, make kids aware. 'Cause they talk about it at home. And then if parents hear some of their kids talking about things that they're not too aware of or they think that they shouldn't know, they tend to be a little bit more interested in what's going on. (BF)

> And I feel sometimes we even learn from our kids, that they will teach their parents, or younger brothers and sisters, or even older brothers and sisters. I think that children should be made aware of--not to be ashamed to talk about it. (BF)

Further, the studying of a subject in school was seen as a tool for opening discussions at home. An example of this was given by one male who explained how he started to talk about sex with his children.

> What happened, they took it up in school and then they come home and they talked about it to us and we had to respond. So they broke the ice and they just made it easier for us to relate to them. (BM)

Literature (Perry, Crockett, & Pirie, 1987) supports the view that youth directed interventions through school have the potential for influencing parental attitudes and knowledge and as well as parent-child communication. However, changes in parental behavior as a result of school-based intervention can not rely on the child to volunteer information, holding group meetings, or sending information home from school. Parental behavior changes demand the active participation of the parents. Carefully developed incentives are frequently required to ensure parental involvement and must be built into the program.

Personal Characteristics

The AIDS Educational Model places personal characteristics as another group of modifying factors. This group probably has the most far reaching effect throughout the model. Personal characteristics not only influence the individual's perceptions of the disease directly but also indirectly through their influence on other modifying factors such as the attitudes towards health and sexuality, knowledge of the disease, and preferences in learning strategies.

A group effect, that is personal characteristics, was found to account for the significant differences between scores of the the Metis adult sample and the University adult sample on all attitudes scales. Just what characteristics of these groups caused this effect is not known. Several obvious differences were culture, educational background, and residence. In addition, the Metis sample had a higher percentage of older adults, and possibly a higher percentage of adults who were married. Any of these factors, or a combination of these, or other factors not so easily identified, may have accounted for the differences in group attitudes. Sample comparisons in this research were only used to provide a benchmark or an indication of need, they were not used to identify what factors cause the differences in attitudes. To investigate the relationships between personal characteristics and attitude scores, further research with comparable samples on key variables such as marital status, age, educational level, and socioeconomic status must be done.

Differences were also noted within the Metis adult group. As they all belonged to the same cultural group one might assume that their needs would be very similar. This was true for most needs but some needs were more prominent in a particular age group or gender. For example, females had a more positive attitude towards sexuality, which included a stronger belief in the practice of "safe sex" methods, than the males. This would indicate that during an AIDS educational program, time should be spent with the males to investigate why their belief in the practice of safe sex methods was not as strong as that of the females. For example, is this difference due to misinformation, lack of information, or the feeling that sex should be natural? Identifying what the males perceived as benefits and barriers to practicing safe sex would allow the educator to address these issues in an attempt to increase the probability of practicing safe sex. This difference in sexuality attitudes might also suggest that despite the fact that both males and females reported that individuals were responsible for their own sexual health, that females be provided with the knowledge and skills to direct the action between sexual partners with respect to preventing the spread of AIDS.

A discrepancy, however, was noted when comparing the males' and females' general belief in the practice of safe sex methods when sexually active to their more specific belief in the practice of safe sex methods to prevent the spread of AIDS. When put into the context of preventing the spread of AIDS there was no significant difference in attitudes between the males and females with regards to the practice of safe sex methods. This discrepancy indicates that an educator should not assume that the Metis adults' general attitudes will be directly applied to specific situations or that behaviors exhibited in a specific situation will be transferred to other situations.

Age accounted for other differences among the Metis adults. Multiple range tests always indicated that the significant differences due to age were between the oldest and the youngest age groups. These differences between the adults in the oldest and youngest age groups were seen in their general attitudes towards AIDS, in their belief about taking action to prevent the spread of AIDS, and in their belief about an individual's responsibility for sexual health. In all three cases, the response of the adults in the youngest age group indicated that they were more likely to practice AIDS risk free behaviors. Possible explanations for this response are that the younger adults saw themselves at greater risk of being exposed to AIDS, the younger group had a better knowledge of AIDS and a higher education level. This research did not assess how the personal characteristics affected the perceptions of AIDS, it simply recognized that these characteristics could have influenced them. Personal characteristics were also used to help assess if there were different needs within the Metis adult sample.

Stimulus to Act

The literature suggests that individuals require more than knowledge, attitudes, and skills to adopt a particular behavior. It appears that a stimulus or cue is required to facilitate the behavior change. The Aids Educational Model identifies contact with AIDS, and indirect and direct educational sources as factors that might stimulate the practice of AIDS risk free behaviors.

Contact with AIDS

The Metis adults' lack of contact with AIDS is seen as a definite barrier to the practice of AIDS risk free behaviors. The Metis adults' comments about health behavior change made it quite clear that behavior changes would likely only result from close exposure to the disease, and perhaps only from actual experience with disease symptoms. Even though they stated that it was possible for someone in their community to get AIDS, it is doubtful that this in itself will be sufficient to outweigh the fact that no one has AIDS in the surrounding area. One adult went so far as to suggest that spreading a rumour of an AIDS case in the community would supply incentive for people to attend an AIDS educational program! This suggestion, while not ethically acceptable, does illustrate the need for the program planner to employ creative ways of making the disease more of a reality for the people. Several ways this might be accomplished are by inviting an AIDS victim to speak or by using videos that have AIDS victims talking about the disease.

Indirect Educational Sources

TV, radio, newspapers, magazines, and pamphlets have influenced the Metis adults' perception of AIDS. All the adults had heard about AIDS, and with the exception of one male in the oldest age group, were able to discuss the subject, what they knew about the disease, who should learn about the disease, what they should learn, etc. As with other groups of adults from the general population, the information received from the mass media had led to confusion and anxiety about some of the facts surrounding the disease.

The Metis adults reported a variety of opinions about the usefulness of the indirect educational sources. Newspapers were generally seen as a poor source of information as many adults only read certain sections of the paper such as the sports section and questioned the reliability of what they read. TV was reported to have provided some facts about the disease but usually in bits and pieces. The information seen on TV that appeared to have made the greatest impression was the pain and suffering experienced by AIDS victims. This impression was the result of watching AIDS victims being interviewed or seeing AIDS victims on soap operas. Pamphlets were seen as a more reliable information source, but one that was not available to everyone. In particular, adults who did not access the health orientated facilities, for example, doctors' offices, hospitals, or the health unit, were unlikely to have seen an AIDS pamphlet. In addition to making pamphlets about AIDS more accessible, the adults reported that for pamphlets to be useful, they should present the facts about the disease in a straight-forward clear manner with as little writing as possible.

Direct Sources of Information

The majority of adults had not had the opportunity of attending any educational program about AIDS and felt that information about AIDS should be available within their community. They felt that community members should be informed about health risks using a variety of methods (workshops, one-to-one counseling, printed material, etc.) to allow individuals to choose the method that best suited their personal needs. Although workshops were seen as the preferred method of learning about AIDS, the adults admitted that it would be difficult to get people to attend. Presenting AIDS information to an existing group or in combination with another event such as a community supper were suggested as ways to improve attendance.

There was a clear need expressed for AIDS education programming to be "people orientated". This started with asking community members what they would like to learn and how they would like to learn it. It was also seen in their preference for learning through small group discussions. The adults saw themselves as learning through questions asked by others, as well as, through the opportunity to express their own views. Learning in small groups has been noted in the literature as being effective in changing attitudes about AIDS risk reduction (Valdiserri, Lyter, Kingsley, Leviton, Schofield, Huggins, Ho, & Rinaldo, 1987).

Another aspect of the people orientation was seen in their preferences for AV materials. In AIDS videos, the adults expressed the preference to watch those having actual people discuss the issue, preferably having a medical professional talking informally to a small group of adults. Also stories explaining how AIDS could affect other people living in similar communities as their's were seen as helpful in making the disease and its method of transmission more real.

Although not specifically addressed in this study, the use of dramatic productions about AIDS might be a useful way to incorporate many of the identified needs. Live drama can be exciting and actively involve the audience in an experience. It can allow information about AIDS to be presented simply, clearly, and in a number of different ways. Small groups discussions following the production would allow adults to ask questions, express ideas and feelings, and thus consider the issues at a personal level. Providing AIDS information in a dramatic production could also decrease the discomfort some adults may feel due to the sensitivity of the topic and the related sexual issues by allowing the adults to talk safely about the characters in the production (Ward, 1988). Both the production and the following discussion could be targeted to the specific educational needs of the Metis adults.

At a workshop, information about AIDS to be seen as credible to the Metis adults should be presented by people knowledgeable about the disease and able to communicate with the people. Trained community members were not seen by most adults to be as credible as a medical professional, either doctor or community health nurse. Generally presenters from outside the community were seen as having more credibility than those within. But if those presenting the information were from too far away , it was suggested that they would not understand the local situation or be able to provide any follow-up.

Summary

Applying the data to the AIDS Educational Model shows that the probability of the Metis adults practicing AIDS risk free behaviors would be influenced by increasing the adults' access to accurate information about the disease and how to prevent its spread; making the disease more "real", that is, enabling the adults to realize the true possibility of the disease being contracted by someone in their community and how this would affect them; increasing their comfort level regarding the discussion of sexual issues; and trying to identify how health changes might be made without having to experience serious consequences of a disease. While most of these needs applied to all Metis adults, there were differences to the extent the needs were expressed according to gender and age.

Males appear to have a greater need to decrease their fear about AIDS, to understand the importance of practicing "Safe Sex" and other AIDS risk free behaviors before they experience symptoms of the disease than do the females; older adults more than the younger adults, appear to have a greater need for accurate information about the disease and for understanding their role in helping to prevent the spread of AIDS and other sexually transmitted diseases. Using a "people orientated" approach and a variety of methods were seen as ways to enhance the probability of practicing the desired behaviors associated with preventing AIDS.

CHAPTER 7

IMPLICATIONS, LIMITATIONS, and RECOMMENDATIONS

Program Planning Implications

The probability of the Metis adults practicing AIDS risk free behaviors can be enhanced by building on the identified needs. Educators should strive to stress the needs perceived as benefits to the practice of AIDS risk free behavior and reduce or eliminate those perceived as barriers. The data suggest that increasing the practice of AIDS risk free behaviors among this population of Metis adults can best be achieved by assisting adults in their desire to protect their children against the disease. Therefore adults need to be prepared to be role models, teachers, and evaluators as well as society shapers. To accomplish this, Metis adults need:

1. Accurate knowledge about AIDS and how to prevent its spread.
2. Increased comfort with discussing sexual issues.
3. Information about when, how, and what to teach children about sex in general and more specifically about AIDS.
4. Skills in implementing the teaching role.
5. Increased feelings of control over their lives so that health changes can be made before serious consequences are felt.

The above needs can best be achieved by:

1. Providing information in a variety of ways : workshops, personal contact, information in the community newsletter or at general meetings, and access to pamphlets, books, and videos. Pamphlets, books and videos should be those that would appeal to the adults, that is bright, eyecatching, and providing clear straight facts with not too much reading.
2. Incorporating a "people orientated"' approach, that is, asking the people for direction regarding program content and process, personally inviting people to attend

information sessions, providing information to small groups and allowing for group discussions, using AV materials that feature actual people, and possibly inviting people who have AIDS or are HIV positive to talk to the Metis adults.

3. Providing information to both men and women--preferably at the same time. The use of techniques such as a question box could increase the comfort level in mixed sessions.
4. Encouraging women to take an active role in promoting the practice of AIDS risk free behaviors both in their own relationships and those of their children.
5. Having an individual who is knowledgeable about AIDS provide information utilizing the adults' preferred learning strategies. Medical professionals are seen as authorities in this area.
6. Working together with the school; showing adults how they can enhance the information that students learn at school about AIDS.

Limitations of the Study

Few research studies are completed without experiencing some situations that are problematic. One limitation of this study is the the nature of the obtained sample. While a random sample representing 25% of the adult community was desired, it was not achieved. This was partially the result of trying to complete the study during the summer and early fall when many of the potential participants were on holidays or busy with outdoor activities. In addition it was difficult to get many of the younger male adults, and especially those who were single, to participate. The volunteer nature of the study may also have contributed to a less accurate description of health education needs regarding AIDS and AIDS prevention by screening out people who were not comfortable with the subject of AIDS and the surrounding issues of sexuality.

Another limitation was the research design that required the adults' participation on two occasions. Of the adults who were interviewed, only 42% of them participated in the assessment of AIDS educational materials, the other 58% did not. If the educational materials had been assessed as part of the interview, it is possible the preferences in materials would have been different.

The third limitation was the lack of data from similar adult groups. The inability to make comparisons with similar rural groups made it impossible to fully assess the influence of personal or cultural characteristics on perceptions of AIDS. The assessment would also have benefited from data illustrating the relationships between attitudes towards AIDS, sexuality, and health and the practice of AIDS risk free behavior.

Finally, as the focus of this study was to identify and assess the unique needs of a particular group of Metis adults, there is no way of knowing if these results can be generalized to other groups of adults, either Metis or non-Metis. This study does though, provide a beginning point from which comparisons can be made to needs identified for other groups of adults.

Recommendations for Further Research

1. The study identified a need to find ways to increase the probability of health behavior change as a result of knowledge, attitudes, and skills because the consequences of waiting to make changes only after experiencing AIDS symptoms may be fatal.
2. It would be useful to survey other populations, both Metis and non-Metis, in order to test the relationships between the observed variables that influence the probability of practicing AIDS risk free behaviors.
3. Research on how the scores on the attitude scales relate to actual behavior change with respect to reducing the risk of contracting AIDS would assist in the assessment of needs.

REFERENCES

Abella, R. (1984). Equality in employment. A royal commission report. Ottawa: Ministry of Supply and Services.

Alberta Community and Occupational Health. (1987). Education and caring: Alberta's program for the prevention, management, and control of AIDS. Edmonton: Alberta Community and Occupational Health.

Alberta Community and Occupational Health. (1988). The Alberta AIDS survey, December, 1987. Edmonton: Alberta Community and Occupational Health.

Alberta Community and Occupational Health. The facts on AIDS. Edmonton: Alberta Community and Occupational Health.

American College Health Association. (1987). AIDS . . .What everyone should know. Rockville, Maryland: American College Health Association.

American College Health Association. (1987). Making sex safer. Rockville, Maryland: American College Health Association.

Anderson, A. (1977). Some Native herbal remedies. Edmonton: Friends of Botanic Garden of the University of Alberta, Department of Botany.

Antonovsky, A., & Hartman, H. (1974). Delay in the detection of cancer: A review of the literature. Health Education Monographs, 2, 98-128.

Becker, M. H. (Ed.). (1974). The health belief model and personal health behavior. Thorofare, NJ.: Slack.

Becker, M. H., Drachman, R. H., & Kirscht, J. P. (1974). A new approach to explaining sick-role behavior in low-income populations. American Journal of Public Health, 64, 205-216.

Biddle, B. J., Bank, B. J., & Marlin, M. M. (1980). Parental and peer influence an adolescents. Social Forces, 58(4), 1057-1079.

Billy, J. O., & Udry, J. R. (1985). Patterns of adolescent friendship and effects on sexual behavior. Social Psychology Quarterly, 48(1), 27-41.

Bouton, R. A., Gallaher, P. E., Garlinghouse, P. A., Leal,T., Rosenstein, L. D., & Young, R. K. (1987). Scales for measuring fear of AIDS and homophobia. Journal of Personality Assessment, 51(4), 606-614.

Breckon, D. J., Harvey, J. R., & Lancaster, R. B. (1985). Community health education: Settings, roles, and skills. Rockville, Maryland: Aspen.

Brown, B. B., Clasen, D. R., & Eicher, S. A. (1986). Perceptions of peer pressure, peer conformity dispositions, and self-reported behavior among adolescents. Developmental Psychology, 22(4), 521-530.

Buller, E., & Hagey, R. (1982, November). Drumming and dancing: A model for diabetes education. Paper presented at the meeting of the American Public Health Association , Montreal, Quebec.

Canadian Public Health Association. (1987). Videotape of AIDS commercials from around the world. Ottawa: Canadian Public Health Association.

Canadian Public Health Association. (1988). AIDS: The new facts of life. Ottawa: Canadian Public Health Association.

Cardell, N. S., Kanouse, D. E., Gorman, E. M., Serrato, C., Reuter, P. H., & Williams, A. P. (1987). Modeling the spread of human immunodeficiency virus in the United States. Paper presented at III International Conference on AIDS, Washington, DC.

Cardinal, P., & Ripley, D. (1988). Canada's people: The Metis. Edmonton: Plains.

Center for Population Options. (1987). AIDS and adolescents. Washington, DC: Center for Population Options.

DeGruttola, V., & Mayer, K. (1987). Assessing and modeling heterosexual spread of the human immunodeficiency virus in the United States. Paper presented at III International Conference on AIDS, Washington, DC.

Dignan, M. B., & Carr, P. A. (1987). Program planning for health education and health promotion. Philadelphia: Lea & Febiger.

Douaud, P. C. (1983). Canadian Metis identity: A pattern of evolution. Anthropos, 78, 71-88.

Edgar,T., Freimuth, V. S., & Hammond, S. L. (1988). Communicating the AIDS risk to college students: The problem of motivating change. Health Education Research, 3(1), 59-65.

Edmonton Board of Health. (1987). Perceptions and attitudes towards AIDS and AIDS prevention among youths and parents. Edmonton: The Edmonton Interagency Council on AIDS.

Elizabeth Metis Settlement Association Council. (1979). Elizabeth Metis Settlement: A local history. Altona, Manitoba: Friesin.

Emmons, C., Joseph, J. G., Kessler, R. C., Wortman, C. B., Montgomery, S. B., & Ostrow, D.G. (1986). Psychosocial predictors of reported behavior change in homosexual men at risk for AIDS. Health Education Quarterly, 13(4), 331-345.

Epp, J. (1986). Achieving health for all: A framework for health promotion. Ottawa: National Health and Welfare Canada.

Ewles, L., & Simnett, I. (1985). Promoting health: A practical guide to health education. New York: John Wiley & Sons.

Francis, D.P., & Chin, J. (1987). The prevention of acquired immunodeficiency syndrome in the United States. Journal of American Medical Association, 257(10), 1357-1366.

Gilmore, N. (1988). Sex, AIDS and cultural change. Sieccan Journal, 3(4), 3-13.

Green, L. W. , Kreuter, M. W., Deeds, S. G., & Partridge, K. B. (1980). Health education planning: A diagnostic approach. USA: Mayfield Publishing Co.

Greene, W. H., & Simons-Morton, B. G. (1984). Introduction to health education. New York: Macmillan Publishing Co.

Greig, J. D. (1987). AIDS: What every responsible Canadian should know. Toronto: Toronto Sun Publishing Corporation & Canadian Public Health Association (Ottawa).

Griggs, J. (Ed.). (1987). AIDS: Public policy dimensions. New York: United Hospital Fund of New York.

Harmon, D. (1976). Curriculum development for nonschool population. In D. Kline & D. Harmon. (Eds.). Issues in population education. Toronto: Lexington Books.

Hastings, G. B., & Scott, A. C. (1987). AIDS publicity: Pointers to development. Health Education Journal, 46(2), 58-59.

Health and Welfare, Canada. (1985). AIDS in Canada: What you should know. Ottawa: Health and Welfare, Canada.

Jenkins, D. C. (1966). Group differences in perception: A study of community beliefs and feelings about tuberculosis. American Journal of Sociology, 71, 417-438.

Kamis, E. (1979). A witness for the defense of need assessment. Evaluation and Program Planning, 2, 7-12.

Kapila, M. (1988). AIDS: A global perspective. Health Promotion, 3(3), 329-335.

Kaufman, R., & English, F. W. (1979). Needs assessment. Englewood Cliffs, N.J.: Educational Technology Publications.

Kegeles, S. S. (1963). Why people seek dental care: A test of a conceptual formulation. Journal of Health and Human Behavior, 4, 166-173.

Kieren, D. K., Judge, L. C., & Mahaffey, B. (1988). Developing three attitude scales as needs assessment tools for adult AIDS educational programming. Unpublished manuscript, University of Alberta, Department of Family Studies, Edmonton, Alberta

Kleinschmidt, H. E., & Zimand, S. (1953). Public health education: Its tools and procedures. New York: MacMillan.

Leo, J. (1986, November 24). Sex and schools. Time, 128, pp. 72-78, 81.

MacEwan, G. (1981). Metis makers of history. Saskatoon, Saskatchewan: Western Producer Prairie Books.

Mason, J. O., Noble, G. R., Lindsey, B. K., Kolbe, L. J., Van Ness, P., Bowen, G. S., Drotman, D. P., Rosenberg, M. L. (1988). Current CDC efforts to prevent and control human immunodeficiency virus infection and AIDS in the United States through information and education. Public Health Reports, 103(3), 255-261.

DiClemente, R. J., & Boyer, C. B. (1987). Ethnic and racial misconceptions about AIDS. Focus, 2(3), 3.

Newman, M. (1987). AIDS experience in seven European countries. Health Education Journal, 46(2), 46-49.

Perry, C. L., Crockett, S. J., & Pirie, P. (1987). Influencing parental health behavior: Implications of community assessments. Health Education, 18(5), 68-76.

Poelzer, D. T., & Poelzer, I. A. (1986). In our own words: Northern Saskatchewan Metis women speak out. Saskatoon, Saskatchewan: Lindenblatt and Hamonic.

Price, R. D. (1982). Determining educational and training needs. Viewpoints in Teaching and Learning, 58, 24-31.

Sarner, M. (1984). Marketing health to Canadians. Health Education, Fall, 2-9.

Scotti, A. T., & Moore, T. A. (1987). Safe sex: What everyone should know about sexually transmitted diseases. Toronto: PaperJacks.

Sealey, D. B., & Lussier, A. S. (1975). The Metis: Canada's forgotten people. Winnipeg, Manitoba: Manitoba Metis Federation Press.

Siegel, L. M., Attkisson, C. C., & Carson, L. G. (1978). Need identification and program planning in the community context. In C. C. Attkisson, W. A. Hargreaves, M. J. Horowitz, & J. E. Sorenson (Eds.), Evaluation of human service programs. New York: Academic Press.

Siegel,K., & Gibson, W. c. (1988). Barriers to the modification of sexual behavior among heterosexuals at risk for acquired immunodeficiency syndrome. New York State Journal of Medicine, 88(2), 66-70.

Slavin, H., & Smith, K. (1987). People's need for information - the work of the National Advisory Service on AIDS. Health Education Journal, 46(2), 60-61.

Solomon, M. Z., & DeJong, W. (1986). Recent sexually transmitted disease prevention efforts and their implications for AIDS health education. Health Education Quarterly, 13(4), 301-316.

Somers, A. R. (Ed.). (1976). Promoting health: Consumer education and national policy. Germantown, Maryland: Aspen.

Steigbigel, N. H., Maude, D. W., Feiner, C. J. Harris, C. A. , Saltzman, B. R., & Klein, R. S. (1987). Heterosexual transmission of infection and disease by the human immunodeficiency virus (HIV). Paper presented at III International Conference on AIDS, Washington, DC.

Suzuki, D. (1987). David Suzuki talks about AIDS. Toronto: General Publishing Paperbacks.

Taba, H. (1962). Curriculum development: Theory and practice. New York: Harcourt, Brace & World, Inc.

Tarasoff, K. J. (1980). Persistent ceremonialism: The Plains Cree and Saulteaux. (Canadian Ethnology Service Paper No. 69). Ottawa: National Museums of Canada.

Valdiserri, R. O., Lyter, D. W., Kingsley, L. A., Leviton, L. C., Schofield, J. W., Huggins, J., Ho, M., & Rinaldo, S. R. (1987). The effect of group education on improving attitudes about AIDS risk reduction. New York State Journal of Medicine, 87(5), 272-278.

Ward, L. (1988). Drama: An effective way to educate about AIDS. Social Casework: The Journal of Contemporary Social Work, 69(6), 393-396.

Williams, L. S. (1986). AIDS risk reduction: A community health education intervention for minority high risk group members. Health Education Quarterly, 13(4), 407-421.

Witkin, B. R. (1984). Assessing needs in educational and social programs. San Francisco: Jossey-Bass.

Wober, J. M. (1988). Informing the British public about AIDS. Health Education Journal, 3(1), 19-24.

Woodroof, J. T. (1986). Reference groups, religiosity, and premarital sexual behavior. Journal for the Scientific Study of Religion, 25(4), 436-460.

World Health Organization. (1986). Health promotion definition. Cited in J. Epp. (1986). Achieving health for all: A framework for health promotion. Ottawa: National Health and Welfare Canada.

APPENDIX A

Instruments

INTERVIEW QUESTIONS

HEALTH BELIEFS

a. What does it mean to you to be healthy?

b. How does one keep healthy?

c. How did you learn the ways to stay healthy?

d. What do you do when you are not feeling well (sick) ?

e. If you found out that some things you normally do could make you sick, would you change what you are doing?

f. What kinds of things might cause you to change what you are doing, so you would be more healthy?

g. Does the church sometimes help you decide things about your health? How?

h. There seems to be a trend towards using natural kinds of cures for things, such as herbs and roots. What do you think of this?
Have you ever tried any of these things? If so, what?
Are you aware if people continue to see traditional healers ie. medicine men or women?

i. Are there any other things about health that are important to you?

j. Are there things that are needed in your community for people living here to be healthy?

HEALTH Attitude Scale

10. A person's health tells a lot about their behavior. SA A U D SD
11. Spiritual leaders have something important to say about a person's health. SA A U D SD
12. A person's behavior determines how healthy he or she is. SA A U D SD
13. Without a spiritual life a person isn't healthy. SA A U D SD
14. Being healthy means feeling good all over. SA A U D SD

SEXUALITY BELIEFS

a. Sex is a subject that is often not talked about much. Why do you think that might be?
Do you talk about sex? With whom?

b. How do people in this community learn about sex ?

c. Who do you think should teach children about sex? - parents, another relative, schools -teacher, health nurse community health representative, a combination?

d. Do you think parents need some assistance in being able to talk to their children about sex? What kinds of things would help?

e. If you had a question about sex, who could you could talk to?

SEXUALITY Attitude Scale

15. Sex is private and shouldn't be talked about. SA A U D SD
16. If you talk about sexual matters it isn't as romantic. SA A U D SD
17. It is OK (not risky) to have more that one sexual partner if you know them. SA A U D SD
18. Avoiding sexual disease in up to the woman. SA A U D SD
19. Avoiding sexual disease is up to the man. SA A U D SD
20. Preventing sexual disease is up to the medical experts. SA A U D SD
21. I would practice safe sex methods when sexually active. SA A U D SD
22. People should be taught to use condoms properly. SA A U D SD

AIDS BELIEFS

a. There has been a lot about AIDS in the news this past year. What does that word AIDS mean to you?

b. Who do you think should learn about AIDS?

c. How important is it for you to learn about AIDS?

d. How important is it for others to learn about AIDS?

e. Do you think you could ever get AIDS?

f. Do you think someone in your community could get AIDS?

g. Do you know someone who has AIDS?

AIDS Attitude Scale

23. AIDS is a serious health risk for teens. SA A U D SD
24. AIDS is a serious health risk for young adults. SA A U D SD
25. AIDS is a serious health risk for everyone. SA A U D SD
26. No matter what you do, if you are going to get AIDS it will happen. SA A U D SD
27. Learning about AIDS is too complicated. SA A U D SD
28. Only sissies worry about getting AIDS. SA A U D SD
29. I don't think I could get AIDS from someone in my own community. SA A U D SD
30. AIDS is God's punishment for a person's sins. SA A U D SD
31. Practicing safe sex methods to prevent AIDS isn't worth the effort. SA A U D SD
32. I would read a pamphlet about AIDS. SA A U D SD
33. Since babies can get AIDS, education won't help. SA A U D SD
34. Talking with a partner about preventing AIDS will destroy the romance. SA A U D SD
35. I would watch a TV program about AIDS. SA A U D SD
36. Only people with many partners get AIDS. SA A U D SD
37. I would go to an educational meeting about AIDS. SA A U D SD
38. Learning about AIDS won't make any difference whether I get AIDS or not. SA A U D SD
39. I would use safe sex methods to prevent the spread of AIDS. SA A U D SD

LEARNING PREFERENCES

a. i) Not many adults have had the opportunity to go to a talk about sex, have you ever attended one? Tell me a little bit about it.

ii) What about a talk on AIDS?

b. If there was something you would like to know about your health, what would you do?

c. i) What would you do if you had a question - about sex?

ii) - about AIDS?

d. Have you read anything about AIDS in the newspapers or magazines?

If yes, - which ones?
- what did you read?

e. What about on TV?

If yes, - special programs? which ones? what did you learn?
- commercials? tell me about the commercial and what you learned

f. There are many pamphlets about AIDS, have you read any?

If yes, - which ones?
- where did you see them?
- were they helpful?

Do you find pamphlets an easy way to learn about how to stay healthy?

Would they be a way to learn about sexual concerns?

g. What books have you read about AIDS?

h. What would be the best way to let people know that they may be at risk regarding something to do with their health? It could be AIDS or some other disease?

i. If health information about AIDS is needed in the community, who should decide how it will be given? -- community? health unit? both? other?

j. Who should provide the information?

- someone from the community? e.g. community health representative, or a community member who has received special training?
- experts from outside? e.g. community health nurse, someone from the STD clinic or AIDS Network?

k. How would you like to learn about AIDS?

- one-to-one, small group, whole community?
- one time only, several sessions?

l. If you wanted to get some information about AIDS when would be a good time?

- time of day
- which day during the week
- which month

m. What kind of information would you like? e.g. content, format , etc.

n. What do you think of students learning about AIDS in school?

AIDS Knowledge Questionnaire

40. A cure is available for AIDS Yes No
41. AIDS affects both men and women. Yes No
42. AIDS can be prevented. Yes No
43. Illegal needle drug users are more likely to get the AIDS virus. (germ) Yes No
44. AIDS is caused by a virus (germ). Yes No
45. Drug abuse, not homosexuality, is the most common risk factor for AIDS. Yes No
46. Everyone who gets the AIDS virus will die from it. Yes No
47. The only way to protect yourself from getting AIDS is by wearing a rubber condom (safe). Yes No
48. AIDS is only passed through sexual contact. Yes No
49. People who use needles for medical purposes are more likely to get the virus. Yes No
50. A person can get AIDS by giving blood. Yes No
51. A person can get AIDS from handling pets. Yes No
52. A person can get AIDS from insect bites. Yes No
53. A person can get AIDS from food, dishes or other objects. Yes No
54. A person can get AIDS from kissing. Yes No
55. A blood test tells if you have AIDS. Yes No
56. People who use drugs or alcohol are more likely to get the AIDS virus. Yes No
57 Having the AIDS virus (germ) is the same as having the disease. Yes No
58. The AIDS virus (germ) can be spread through casual contact, such as touching or being near someone with AIDS. Yes No

FEAR of AIDS Scale

59. I wouldn't mind being in the same room with a friend who has AIDS. SA A U D SD
60. (A centralized) One file containing names of all people known to have the AIDS virus should be kept. SA A U D SD
61. If I found out a friend had AIDS, I would be afraid to hug him/her. SA A U D SD
62. I would object to sending my child to a school which had a child who has AIDS. SA A U D SD
63. I believe public officials when they say AIDS cannot be transmitted through casual contact. SA A U D SD
64. I am afraid that I will get AIDS. SA A U D SD
65. AIDS children should be allowed to attend public school. SA A U D SD

66. Compared with other public health problems, I think AIDS as a very (minor) small problem. SA A U D SD

67. If I found out that my lover had AIDS, I would still have sex with him/her. SA A U D SD

68. The seriousness of AIDS is greatly overblown by the media. SA A U D SD

69. AIDS will become a severe and widespread epidemic. SA A U D SD

70. I am worried about catching AIDS in a public washroom. SA A U D SD

71. Even if a friend had AIDS, I wouldn't mind touching him/her. SA A U D SD

72. If I found out a friend or lover had AIDS I would be afraid to kiss him/her. SA A U D SD

DESCRIPTION OF AIDS EDUCATIONAL MATERIALS VIEWED AND DISCUSSION QUESTIONS

Videos

One of the most common ways of teaching people about all kinds of things, are showing films or videos. Today we will see 3 videos -- they are too long to show the whole video, so we will only be watching parts of each video, those parts that talk about how the disease is spread.

1) AIDS Alert -- produced by Chic Thompson, M. Ed.
2) AIDS: An Epidemic/Knowledge Questionnaire -- This was a video of a US TV program that provides AIDS information through the discussion of results from a AIDS Knowledge poll done in the United States.
3) AIDS: The New Epidemic -- This video was made by the Centre of Disease Control in British Columbia and is hosted by Stu Jeffries. It features Dr. Michael Rekart, Director of the B.C. AIDS Program talking to a high school class about AIDS.

Discussion Questions

A. After each video:

1. What did you like about the video?
2. What did you dislike about the video?
3. Was it easy to follow what was being said?
4. What age group of people in the community could understand this video? (adults - teens - children)
5. Do you believe what is said in the video?
6. Is it interesting to watch?
7. Does any of it turn you off?

B. After viewing all video clips:

1. If you had to choose one of these videos to show at a workshop here in the community, which one would you choose and why?
2. Are videos a good way to learn about health concerns? Why?
3. Do you think that watching a video could actually persuade you to change some of

things you do? for example - Do you think watching a video would convince you to use condoms if you were going to have sex with more than one partner?

4. What could make the videos better?
   - use Aboriginal people
   - symbols vs real people
   - address more of your concerns? Which ones?
5. Would showing a group of people in a rural setting like your community be better than showing a classroom?
4. Symbols vs real people?

Stories

Another method of teaching about AIDS is through story telling. This is a story about Samuel and Shari (from the AIDS Teaching Package, Medical Services, Health and Welfare, Canada, see story pg. 133)

Discussion Questions:

1. What message does the story have for you?
2. Do you like learning about AIDS through stories? Why? Why not?
3. Who would find learning this way helpful?

Pamphlets

There are quite a number of pamphlets about AIDS. Let's take a few minutes to look at these ones. The pamphlets used were:

1. The Facts on AIDS (Alberta Community and Occupational Health)
2. AIDS. . . What Everyone Should Know (American College Health Association, 1987)
3. Making Sex Safer (American College Health Association, 1987)
4. AIDS : The New Facts of Life (Canadian Public Health Association, 1988)
5. AIDS Information sheet--(see example pg. 134)

Discussion Questions:

1. Which pamphlet would you pick up? Why?
   - would you read the whole thing?
   - is the information easy to understand?
   - does it answer all your questions about AIDS?

Anything you dislike about pamphlets?

2. Who would find pamphlets a useful source of information?
3. Where should you be able to get pamphlets about AIDS?
4. Would you rather see a pamphlet about AIDS that has pictures in it something like this TB pamphlet?

Demonstration (proper use of a condom)

Discussion Questions:

1. What do you think about showing the proper use of condoms as part of an AIDS program?

   Who should see this demonstration? adults, teens
2. Would it make any difference if the demonstration was done as I just did for you, or if you saw it on a video?
3. Do you think seeing a demonstration and having a chance to practice helps people learn?
4. Should rubbers be available in the community? If so, where? Should they be free?

Books

Another way many people learn about things is by reading books. There are many books about AIDS in the bookstores. Pass around examples - AIDS: What Every Responsible Canadian Should Know (Greig, 1987), Safe Sex (Scotti, 1987) and David Suzuki Talks about AIDS (Suzuki,1987).

Discussion Questions:

1. Would you buy a book to learn about AIDS? Why?
2. What about taking a book out of the library?
3. Should these books be available in the community?

Wrap-up Discussion Questions:

* Now that you have seen some ways to learn about AIDS, what would you like to see in an AIDS program?

-- methods

-- information

* Are there other health questions or concerns besides AIDS, that should be talked about in the community?

STORY WHICH ILLUSTRATES HOW HIV IS TRANSMITTED
from the AIDS Teaching Package, Medical Services, Health and Welfare Canada

Samuel and Shari

Samuel and Shari are from the same northern community. In their community, there is not much work available. Like other young people in their community, they decided to go down south to find a job. While they are down south, they start seeing one another.

One night, Samuel went to a party, and his buddies urged him to try some I.V. drugs. He has never used drugs before, but decides he will try it just once. His friends show him what to do. Samuel doesn't know it, but one of the other guys he is shooting with has been infected with the virus that causes AIDS. Samuel becomes infected too. A lot of people were high on drugs that night, and they were doing things they may not be doing otherwise, The next morning, Samuel cannot recall everything that happened.

Samuel's girl friend, Shari, has sex with Samuel. She becomes infected with the virus too, but neither of them knows this.

It has been hard for them to find a regular job, and after several frustrating months, they have a fight and break up. Both decide to go back to their community up north.

Back in the community, Samuel meets Carol and becomes sexually involved with her. Shari starts going steady with Joe, and in time they develop a sexual relationship too. Carol and Joe become infected with the virus, as do some other people Samuel had been seeing.

As each of these individuals continues, over time, to have unsafe sex and/or use I.V. drugs with others, the virus continues to spread in this small community.

It is now three years since Samuel went to the party where he was infected. He left the settlement about six months ago, and no one has heard from him since.

You and I come into the picture here where people in our families might become involved with one of these people who has had direct, or indirect contact with Samuel, Shari, Carol, or Joe. Perhaps these people experiment with sex or IV. drugs only once -- but that once is enough for them to become infected. Or perhaps they have not experimented at all with sex or drugs, but have decided to marry one of the infected people. Because the virus that causes AIDS can incubate for several years, no one even suspects himself or herself to be at risk. Everyone in this story looks and feels very healthy.

AIDS

What is AIDS?

AIDS is a disease caused by a germ.

What do AIDS germs do to my body?

AIDS germs attack your defense system in your body and cause you to get sick.

How do you catch AIDS?

You catch AIDS by having sex with a man or woman who has AIDS germs in their body.

OR

You catch AIDS by sharing needles when you do drugs.

OR

A baby can catch AIDS from its mother before it is born.

How do I know that I don't have AIDS?

A doctor will take a blood test and check your blood for AIDS germs.

What would it mean if I have AIDS germs in my blood?

It would mean that you have the AIDS germs in your body.

It may not mean you have AIDS.

******* **If you have the AIDS germs in your body, you can give it to men and women that you have sex with. This causes them to get the AIDS germs in their body too!**

What does it mean if I don't have AIDS germs in my blood?

It might mean that you do not have AIDS germs in your body

OR

It might mean that the AIDS germs have not started to grow in your body yet.

******* **AIDS germs can take months to grow in your body!**

How can I protect myself from catching AIDS?

Wear a rubber, safe, or condom when you have sex with a man or woman.

AND

Never share needles or syringes when you do drugs.

******* **You may want to talk to a doctor about AIDS, or**
Call the Health Line at 428-4288 and ask for tape 571,
or call AIDS Info at 1-800-772-AIDS
1-800-772-2437

North Eastern Alberta Health Unit

Box 1468 - St. Paul, Alberta, Canada - T0A 3A0
Telephone: (403) 645-3396

Informed Consent Form

Title: Identifying AIDS Educational Needs of Adults

Researcher : Lucy Judge	**Telephone: 594-2227** **or 962-4258**
Supervisor: Dr. Dianne Kieren	**Telephone: 432-8181**
Health Unit: Mrs. Rita Bell	**Telephone: 645-3396**

The purpose of this study is to find out how and what the adults in your community would like to learn about the disease AIDS. The results of this study can then be used by your community and the health unit to plan an AIDS education program.

This study has two parts. The first is a personal interview that will last about one hour. The second part, on another day, will be to have small groups of adults look at videos and pamphlets about AIDS that are being used in other places. Both the interview and the small group session will be tape recorded. All information will be kept confidential. No one from the community will be able to find out how individuals answered the questions. The report of the study will not include names.

You may ask questions at any time and may refuse to answer any questions you choose.

You may end the interview or leave the group session at any time.

I agree to take part in this study.

______________________________ ______________________

Signature of the Participant Date

Viewing and discussing AIDS educational materials Group ________

A. VIDEOS

i. AIDS Alert

1. **What I like about this video**

____

____

2. **What I dislike about this video**

____

____

3. **I found this video easy to follow** yes no

4. **This video could be understood by the following people in my community:**

adults
strongly agree agree undecided disagree strongly disagree
teens
strongly agree agree undecided disagree strongly disagree
children
strongly agree agree undecided disagree strongly disagree

5. **This video was interesting to watch.**
strongly agree agree undecided disagree strongly disagree

ii. US TV show

1. **What I like about this video**

____

____

2. **What I dislike about this video**

____

____

3. **I found this video easy to follow** yes no

4. **This video could be understood by the following people in my community:**

adults
strongly agree agree undecided disagree strongly disagree
teens
strongly agree agree undecided disagree strongly disagree
children
strongly agree agree undecided disagree strongly disagree

5. **This video was interesting to watch.**
strongly agree agree undecided disagree strongly disagree

iii. BC AIDS video

1. **What I like about this video**

____

____

2. **What I dislike about this video**

____

____

3. **I found this video easy to follow** yes no

4. **This video could be understood by the following people in my community:**

adults
strongly agree agree undecided disagree strongly disagree
teens
strongly agree agree undecided disagree strongly disagree
children
strongly agree agree undecided disagree strongly disagree

5. **This video was interesting to watch.**
strongly agree agree undecided disagree strongly disagree

After watching all the videos:

I would like to see AIDS Alert US TV show BC AIDS video **used in a workshop on AIDS in this community.**

I think videos are a good way to learn about AIDS.
strongly agree agree undecided disagree strongly disagree
Why?______________________________

____

I prefer to have real people talking about AIDS rather than cartoon characters or symbols.
strongly agree agree undecided disagree strongly disagree

To improve the videos, I suggest

____

____

B. STORIES

1. **What did the story tell you?**

____

____

2. **I think reading and talking about stories that tell how people can catch AIDS is a good way to learn about the disease.**
strongly agree agree undecided disagree strongly disagree

3. I think that having the story about how people in a small community can get AIDS helps me understand how the disease can spread.
strongly agree agree undecided disagree strongly disagree

Comments____

C. PAMPHLETS

1. **I think pamphlets are a good way to learn about AIDS.**
strongly agree agree undecided disagree strongly disagree
Why?____

2. **I would pick up this pamphlet.**
#1 #2 #3 #4 #5 none
Why?____

3. **I would read this pamphlet.**
#1 #2 #3 #4 #5 none
Why?____

4. **I do not understand this pamphlet.**
#1 #2 #3 #4 #5 none

5. **I would like less writing in the pamphlets.**
strongly agree agree undecided disagree strongly disagree

Comments____

E. DEMONSTRATION OF THE PROPER USE OF A CONDOM

1. I think seeing a demonstration and having a chance to practice is a good way to learn.
strongly agree agree undecided disagree strongly disagree

2. I think adults should be shown how to use a condom (safe or rubber).
strongly agree agree undecided disagree strongly disagree

3. I think teens should be shown how to use a condom (safe or rubber).
strongly agree agree undecided disagree strongly disagree

4. As part of an AIDS program, you should be able to touch a condom.
strongly agree agree undecided disagree strongly disagree

5. I would prefer to see the demonstration on video.
strongly agree agree undecided disagree strongly disagree

6. I think that seeing a demonstration and having a chance to practice helps people learn.

strongly agree agree undecided disagree strongly disagree

7. I think condoms should be available in the community.

strongly agree agree undecided disagree strongly disagree

If so,
where?____

Comments____

____

F. BOOKS

1. I think books on different health subjects should be available in the community.

strongly agree agree undecided disagree strongly disagree

2. I would borrow and read a health book if it was available in the community.

strongly agree agree undecided disagree strongly disagree

What I would like to see in a workshop on AIDS is:

____

____

____

APPENDIX B

Metis and University of Alberta Comparison Tables

Table B.1

Scores for the Attitude Scales for the Metis and University of Alberta (U OF A) Adults.

	METIS ADULTS				U of A ADULTS				F value		
	MALE (n=20)		FEMALE (n=25)		MALE (n=24)		FEMALE (n=92)		Main effects		
SCALES/Subscales Interaction	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Group	Gender	
HEALTH	18.45	3.22	18.60	3.11	15.54	3.92	14.94	3.84	.000	.626	.587
General health	11.80	1.6	12.12	2.35	10.17	2.58	9.67	2.10	.000	.673	.392
Spirituality	6.65	1.95	6.48	1.23	5.38	2.18	2.67	7.12	.001	.626	.587
SEX	30.25	2.69	32.44	2.90	33.88	3.56	35.25	3.81	.000	.010	.541
Responsibility for prevention	12.60	1.64	12.48	1.45	12.99	2.74	13.07	2.90	.280	.960	.816
Sexual privacy	10.40	2.04	11.96	1.57	12.25	1.45	13.11	1.49	.000	.000	.239
Behavioral responsibility	7.25	1.02	8.00	1.12	8.67	1.05	9.08	.84	.000	.002	.340
	(n=19)										
AIDS	65.95	6.35	66.80	5.54	67.88	6.24	70.37	5.35	.004	.067	.446
Motivation	11.74	1.24	12.36	.86	11.92	1.77	13.11	1.39	.029	.000	.279
Risk	13.42	1.35	13.00	1.63	12.08	2.15	12.17	1.90	.003	.780	.467
Disbelief	15.21	2.20	15.28	1.79	16.33	2.28	17.86	1.78	.000	.005	.047
Fate	6.95	1.81	7.24	1.74	9.29	.86	9.17	1.06	.000	.895	.396
Lack of action	14.79	2.76	14.84	2.63	17.33	1.71	17.57	1.87	.000	.666	.821
Safe sex	3.84	.60	4.08	.49	4.50	.51	4.64	.55	.000	.077	.640
FEAR of AIDS	29.47	5.31	26.52	4.92	25.00	5.21	24.82	6.19.	.012	.263	.210

Table B.2

Knowledge Level of AIDS for the Metis and University of Alberta Samples

Valid % with Correct Response

Knowledge of AIDS Questions	Correct Response	METIS Total	METIS Male	METIS Female	UNIVERSITY OF ABLERTA Total	UNIVERSITY OF ABLERTA Male	UNIVERSITY OF ABLERTA Female
base size		44	19	25	111	23	88
A cure is available for AIDS.	False	88.4^a	77.8^b	96.0	[109] 93.6	[23]100.0	[86] 91.9
AIDS affects both men and women.	True	100.0	100.0	100.0	[110] 99.1	[23]100.0	[87] 98.9
AIDS can be prevented.	True	95.5	100.0	92.0	[108] 94.4	[23] 95.7	[85] 94.1
Illegal needle drug users are more likely to get the AIDS virus(germ).	True	97.7	100.0	96.0	[109] 95.4	[23] 91.3	[86] 96.5
AIDS is caused by a virus (germ).	True	97.7	100.0	96.0	[107] 90.7	[23] 91.3	[84] 90.5
Drug abuse, not homosexuality, is the most common risk factor for AIDS.	False	45.5	31.6	56.0	[104] 71.2	[23] 73.9	[81] 70.4
Everyone who gets the AIDS virus will die from it.	False	22.7	31.6	16.0	[106] 63.2	[22] 63.6	[84] 63.1
The only way to protect yourself from getting AIDS is by wearing a rubber condom (safe).	False	65.9	63.2	68.0	[109] 84.4	[23] 95.7	[86] 81.4
AIDS is only passed through sexual contact.	False	77.3	84.2	72.0	[110] 90.9	[23] 95.7	[87] 89.7
People who use needles for medical purposes are more likely to get the virus.	False	86.4	78.9	92.0	[109] 62.4	[23] 65.2	[86] 61.6
A person can get AIDS by giving blood.	False	54.5	47.4	60.0	[109] 86.2	[23] 87.0	[86] 86.0
A person can get AIDS from handling pets.	False	84.1	68.4	96.0	[108] 91.7	[22] 90.9	[86] 91.9
A person can get AIDS from insect bites.	False	65.9	57.9	72.0	*******	*********	******
A person can get AIDS from food, dishes or other objects.	False	77.3	63.2	88.0	[106] 99.1	[22]100.0	[84] 98.8
A person can get AIDS from kissing.	False	70.5	57.9	80.0	[103] 68.9	[22] 68.2	[81] 69.1
A blood test tells if you have AIDS.	True	90.9	89.5	92.0	[107] 81.3	[23] 82.6	[84] 81.0
People who use drugs or alcohol are more likely to get the virus.	True	60.5^c	72.2^d	52.0	[108] 30.6	[23] 30.4	[85] 30.6
Having the AIDS virus (germ) is the same as having the disease.	False	34.1	21.1	44.0	[103] 81.6	[23] 82.6	[80] 81.3
The AIDS virus (germ) can be spread through casual contact, such as touching or being near someone with AIDS.	False	84.1	73.7	92.0	[107] 97.2	[22]100.0	[85] 96.5

Note. $a_n = 43$; $b_n = 18$; $c_n = 43$; $d_n = 18$ Bracketed numbers are n's for specific items.
* = item missed

APPENDIX C

Percentage Analysis of the Metis Adults' Responses to Individual Items on the Attitude Scales

Item Analysis Percentage Response of the Male Adults to the Attitude Scales.

HEALTH ATTITUDE SCALE

		Percent Response				
General Health Subscale	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
A person's health tells a lot about their behavior.	18-30	33.3	33.3	16.7	16.7	0
	31-45	33.3	66.7	0	0	0
	46+	0	87.5	0	12.5	0
	total	20.0	65.0	5.0	10.0	0
A person's behavior determines how healthy he or she is.	18-30	0	66.7	16.7	16.7	0
	31-45	16.7	83.3	0	0	0
	46+	25.0	37.5	25.0	12.5	0
	total	15.0	60.0	15.0	10.0	0
Being healthy means feeling good all over.	18-30	50.0	50.0	0	0	0
	31-45	0	83.3	0	16.7	0
	46+	0	100.0	0	0	0
	total	15.0	80.0	0	5.0	0
Spirituality Subscale						
Spiritual leaders have something important to say about a person's health.	18-30	0	50.0	16.7	33.3	0
	31-45	0	50.0	16.7	33.3	0
	46+	12.5	37.5	12.5	37.5	0
	total	5.0	45.0	15.0	35.0	0
Without a spiritual life a person isn't healthy.	18-30	16.7	16.7	16.7	33.3	16.7
	31-45	33.3	50.0	0	16.2	0
	46+	12.5	50.0	12.5	25.0	0
	total	20.0	40.0	10.0	25.0	5.0

Note. n's for males 18-30 years = 6; 31-45 years = 6; 46+ years = 8; total = 20

SEXUALITY ATTITUDE SCALE

		Percent Response				
Sexual Privacy Subscale	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Sex is private and shouldn't be talked about.	18-30	16.7	33.3	0	33.3	16.7
	31-45	0	0	16.7	83.3	0
	46+	0	12.5	25.0	62.5	0
	total	5.0	15.0	15.0	60.0	5.0
If you talk about sexual matters it isn't as romantic.	18-30	0	16.7	16.7	66.7	0
	31-45	0	0	16.7	83.3	0
	46+	12.5	12.5	25.0	50.0	0
	total	5.0	10.0	20.0	65.0	0
It is OK (not risky) to have more that one sexual partner if you know them.	18-30	0	16.7	0	66.7	16.7
	31-45	0	0	0	100.0	0
	46+	0	50.0	12.5	37.5	0
	total	0	25.0	5.0	65.0	5.0

Responsibility for Prevention Subscale	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Avoiding sexual disease in up to the woman.	18-30	0	0	0	33.3	66.7
	31-45	0	0	0	66.7	33.3
	46+	0	0	0	100.0	0
	total	0	0	0	70.0	30.0
Avoiding sexual disease is up to the man.	18-30	0	0	0	33.3	66.7
	31-45	0	0	0	66.7	33.3
	46+	0	25.0	0	75.0	0
	total	0	10.0	0	60.0	30.0
Preventing sexual disease is up to the medical experts.	18-30	0	0	0	50.0	50.0
	31-45	0	0	0	66.7	33.3
	46+	0	0	12.5	87.5	0
	total	0	0	5.0	70.0	25.0
Behavioral Responsibility Subscale						
I would practice safe sex methods when sexually active.	18-30	0	50.0	0	50.0	0
	31-45	0	83.3	0	16.7	0
	46+	0	87.5	12.5	0	0
	total	0	75.0	5.0	20.0	0
People should be taught to use condoms properly.	18-30	0	83.3	16.7	0	0
	31-45	0	50.0	16.7	33.3	0
	46+	0	100	0	0	0
	total	0	80.0	10.0	10.0	0

Note. n's for males 18-30 years = 6; 31-45 years = 6; 46+ years = 8; total = 20

AIDS ATTITUDE SCALE

		Percent Response				
Risk Factors Subscale	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
AIDS is a serious health risk for teens.	18-30	100	0	0	0	0
	31-45	33.3	66.7	0	0	0
	46+	28.6	71.4	0	0	0
	total	52.6	47.4	0	0	0
AIDS is a serious health risk for young adults.	18-30	100	0	0	0	0
	31-45	33.3	66.7	0	0	0
	46+	14.3	85.7	0	0	0
	total	47.4	52.6	0	0	0
AIDS is a serious health risk for everyone.	18-30	66.7	33.3	0	0	0
	31-45	50.0	50.0	0	0	0
	46+	14.3	85.7	0	0	0
	total	42.1	57.9	0	0	0

Fate Subscale	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
No matter what you do, if you are going to get AIDS it will happen.	18-30	16.7	0	16.7	66.7	0
	31-45	0	3.3	0	50.0	16.7
	46+	0	57.1	0	42.9	0
	total	5.3	31.6	5.3	52.6	5.3
Practicing safe sex methods to prevent AIDS isn't worth the effort.	18-30	0	0	16.7	33.3	50.0
	31-45	0	20.0	0	80.0	0
	46+	0	14.3	0	71.4	14.3
	total	0	11.1	5.6	61.1	22.2
Disbelief Subscale						
Learning about AIDS is too complicated.	18-30	0	0	0	50.0	50.0
	31-45	0	0	0	100	0
	46+	0	28.6	14.3	42.9	14.3
	total	0	10.5	5.3	63.2	21.1
Only sissies worry about getting AIDS.	18-30	0	0	0	66.7	33.3
	31-45	0	0	0	83.3	16.7
	46+	0	0	42.9	57.1	0
	total	0	0	15.8	68.4	15.8
I don't think I could get AIDS from someone in my own community.	18-30	16.7	0	0	50.0	33.3
	31-45	0	16.7	16.7	66.7	0
	46+	0	0	28.6	71.4	0
	total	5.3	5.3	15.8	63.2	10.5
AIDS is God's punishment for a person's sins.	18-30	0	0	33.3	33.3	33.3
	31-45	0	33.3	16.7	50.0	0
	46+	0	28.6	14.3	28.6	28.6
	total	0	21.1	21.1	36.8	21.1
Motivation for Education Subscale						
I would read a pamphlet about AIDS.	18-30	0	100	0	0	0
	31-45	16.7	66.7	0	16.7	0
	46+	0	85.7	0	14.3	0
	total	5.3	84.2	0	10.5	0
I would watch a TV program about AIDS.	18-30	16.7	83.3	0	0	0
	31-45	0	66.7	0	33.3	0
	46+	0	100	0	0	0
	total	5.3	84.2	0	10.5	0
I would go to an educational meeting about AIDS.	18-30	16.7	83.3	0	0	0
	31-45	0	100	0	0	0
	46+	0	100	0	0	0
	total	5.3	94.7	0	0	0
Lack of Action Subscale						
Since babies can get AIDS, education won't help.	18-30	0	0	0	66.7	33.3
	31-45	0	0	0	100	0
	46+	14.3	0	14.3	71.4	0
	total	5.3	0	5.3	78.9	10.5
Talking with a partner about preventing AIDS will destroy the romance.	18-30	0	16.7	0	50.0	33.3
	31-45	0	0	16.7	83.3	0
	46+	0	28.6	14.3	57.1	0
	total	0	15.8	10.5	63.2	10.5

CONTD	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Only people with many partners get AIDS.	18-30	0	33.3	0	50.0	16.7
	31-45	0	0	16.7	83.3	0
	46+	0	57.1	0	42.9	0
	total	0	31.6	5.3	57.9	5.3
Learning about AIDS won't make any difference whether I get AIDS or not.	18-30	0	16.7	0	33.3	50.0
	31-45	0	0	16.7	66.7	16.7
	46+	0	14.3	28.6	57.1	0
	total	0	10.5	15.8	52.6	21.1
Safe Sex Item						
I would use safe sex methods to prevent the spread of AIDS.	18-30	16.7	50.0	33.3	0	0
	31-45	0	83.3	0	16.7	0
	46+	0	100	0	0	0
	total	5.3	78.9	10.3	5.3	0

Note. n's for males 18-30 years = 6; 31-45 years = 6; 46+ years = 7; total = 19

FEAR of AIDS SCALE

Percent Response

Scale items	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
I wouldn't mind being in the same room with a friend who has AIDS.	18-30	0	66.7	0	33.3	0
	31-45	0	50.0	50.0	0	0
	46+	0	71.4	0	28.6	0
	total	0	63.2	15.8	21.1	0
(A centralized) One file containing names of all people known to have the AIDS virus should be kept.	18-30	0	50.0	33.3	16.7	0
	31-45	0	66.7	16.7	16.7	0
	46+	0	57.1	28.6	14.3	0
	total	0	0	57.9	26.3	15.8
If I found out a friend had AIDS, I would be afraid to hug him/her.	18-30	0	16.7	16.7	50.0	16.7
	31-45	0	16.7	0	83.3	0
	46+	0	57.1	0	42.9	0
	total	0	31.6	5.3	57.9	5.3
I would object to sending my child to a school which had a child who has AIDS.	18-30	0	33.3	16.7	33.3	16.7
	31-45	0	16.7	33.3	50.0	0
	46+	0	28.6	0	71.4	0
	total	0	26.3	15.8	52.6	5.3
I believe public officials when they say AIDS cannot be transmitted through casual contact.	18-30	16.7	66.7	16.7	0	0
	31-45	0	83.3	16.7	0	0
	46+	0	71.4	0	28.6	0
	total	5.3	73.7	10.5	10.5	0
I am afraid that I will get AIDS.	18-30	0	50.0	0	0	50.0
	31-45	0	33.3	0	66.7	0
	46+	0	85.7	14.3	0	0
	total	0	57.9	5.3	21.1	15.8

CONTD	MALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
AIDS children should be allowed to attend public school.	18-30	16.7	33.3	33.3	16.7	0
	31-45	0	66.7	16.7	16.7	0
	46+	0	42.9	14.3	42.9	0
	total	5.3	47.4	21.1	26.3	0
Compared with other public health problems, I think AIDS as a very (minor) small problem.	18-30	0	0	0	16.7	83.3
	31-45	0	0	0	100	0
	46+	0	0	14.3	71.4	14.3
	total	0	0	5.3	63.2	31.6
If I found out that my lover had AIDS, I would still have sex with him/her.	18-30	0	0	0	16.7	83.3
	31-45	0	0	16.7	83.3	0
	46+	0	0	14.3	57.1	28.6
	total	0	0	10.5	52.6	36.8
The seriousness of AIDS is greatly overblown by the media.	18-30	0	0	16.7	83.3	0
	31-45	0	0	0	83.3	16.7
	46+	14.3	57.1	0	28.6	0
	total	5.3	21.1	5.3	63.2	5.3
AIDS will become a severe and widespread epidemic.	18-30	0	50.0	50.0	0	0
	31-45	33.3	50.0	16.7	0	0
	46+	0	100	0	0	0
	total	10.5	68.4	21.1	0	0
I am worried about catching AIDS in a public washroom.	18-30	0	16.7	16.7	50.0	16.7
	31-45	0	0	0	100	0
	46+	0	71.4	0	28.6	0
	total	0	31.6	5.3	57.9	5.3
Even if a friend had AIDS, I wouldn't mind touching him/her.	18-30	0	66.7	16.7	16.7	0
	31-45	0	83.3	16.7	0	0
	46+	0	57.1	14.3	28.6	0
	total	0	68.4	15.8	15.8	0
If I found out a friend or lover had AIDS I would be afraid to kiss him/her.	18-30	0	50.0	33.3	16.7	0
	31-45	0	33.3	33.3	33.3	0
	46+	0	57.1	28.6	14.3	0
	total	0	47.4	31.6	21.1	0

Note. n's for males 18-30 years = 6; 31-45 years = 6; 46+ years = 7; total = 19

Item Analysis Percentage Response of the Female Adults to the Attitude Scales.

HEALTH ATTITUDE SCALE

General Health Subscale	FEMALE Age*	Percent Response Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
A person's health tells a lot about their behavior.	18-30	27.3	45.5	18.2	9.1	0
	31-45	44.4	55.6	0	0	0
	46+	60.0	40.0	0	0	0
	total	40.0	48.0	8.0	4.0	0
A person's behavior determines how healthy he or she is.	18-30	27.3	36.4	0	36.4	0
	31-45	22.2	44.4	0	33.3	0
	46+	0	40.0	20.0	20.0	0
	total	28.0	36.0	4.0	32.0	0
Being healthy means feeling good all over.	18-30	18.2	63.6	0	18.2	0
	31-45	55.6	44.4	0	0	0
	46+	80.0	20.0	0	0	0
	total	44.0	48.0	0	8.0	0
Spirituality Subscale						
Spiritual leaders have something important to say about a person's health.	18-30	9.1	18.2	54.5	18.2	0
	31-45	11.1	44.4	22.2	22.2	0
	46+	0	40.0	40.0	20.0	0
	total	8.0	32.0	40.0	20.0	0
Without a spiritual life a person isn't healthy.	18-30	0	45.5	18.2	36.4	0
	31-45	0	44.4	11.1	44.4	0
	46+	20.0	40.0	40.0	0	0
	total	4.0	44.0	20.0	32.0	0

Note. n's for females 18-30 years = 11; 31-45 years = 9; 46+ years =5 ; total = 25

SEXUALITY ATTITUDE SCALE

Sexual Privacy Subscale	FEMALE Age*	Percent Response Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Sex is private and shouldn't be talked about.	18-30	0	0	0	81.8	18.2
	31-45	0	22.2	11.1	44.4	22.2
	46+	0	0	20.0	60.0	20.0
	total	0	8.0	8.0	64.0	20.0
If you talk about sexual matters it isn't as romantic.	18-30	0	0	9.1	72.7	18.2
	31-45	0	66.7	11.1	22.2	0
	46+	20.0	20.0	20.0	40.0	0
	total	4.0	12.0	12.0	64.0	8.0
It is OK (not risky) to have more that one sexual partner if you know them.	18-30	0	0	0	36.4	63.6
	31-45	0	11.1	0	55.6	33.3
	46+	0	0	0	60.0	40.0
	total	0	4.0	0	48.0	48.0

Responsibility for Prevention Subscale	FEMALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Avoiding sexual disease in up to the woman.	18-30	0	0	0	54.5	45.5
	31-45	0	0	0	66.7	33.3
	46+	0	20.0	0	60.0	20.0
	total	0	0	0	64.0	36.0
Avoiding sexual disease is up to the man.	18-30	0	0	0	54.5	45.5
	31-45	0	0	0	66.7	33.3
	46+	0	20.0	0	60.0	20.0
	total	0	4.0	0	60.0	36.0
Preventing sexual disease is up to the medical experts.	18-30	0	9.1	18.2	54.5	18.2
	31-45	0	11.1	11.1	66.7	11.1
	46+	0	20.0	0	40.0	40.0
	total	0	12.0	12.0	56.0	20.0
Behavioral Responsibility Subscale						
I would practice safe sex methods when sexually active.	18-30	18.2	54.5	27.3	0	0
	31-45	11.1	66.7	11.1	11.1	0
	46+	20.0	40.0	40.0	0	0
	total	16.0	56.0	24.0	4.0	0
People should be taught to use condoms properly.	18-30	18.2	72.7	9.1	0	0
	31-45	22.2	77.8	0	0	0
	46+	20.0	80.0	0	0	0
	total	20.0	76.0	4.0	0	0

Note. n's for females 18-30 years = 11; 31-45 years = 9; 46+ years =5 ; total = 25

AIDS ATTITUDE SCALE

		Percent Response				
Risk Factors Subscale	FEMALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
AIDS is a serious health risk for teens.	18-30	27.3	63.6	9.1	0	0
	31-45	66.7	22.2	11.1	0	0
	46+	80.0	20.0	0	0	0
	total	52.0	40.0	8.0	0	0
AIDS is a serious health risk for young adults.	18-30	36.4	54.5	9.1	0	0
	31-45	44.4	44.4	11.1	0	0
	46+	20.0	80.0	0	0	0
	total	36.0	56.0	8.0	0	0
AIDS is a serious health risk for everyone.	18-30	36.4	63.6	0	0	0
	31-45	44.4	44.4	11.1	0	0
	46+	20.0	80.0	0	0	0
	total	36.0	60.0	0	4.0	0

Fate Subscale	FEMALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
No matter what you do, if you are going to get AIDS it will happen.	18-30	9.1	27.3	0	54.5	9.1
	31-45	0	44.4	0	44.4	11.1
	46+	0	40.0	0	60.0	0
	total	4.0	36.0	0	52.0	8.0
Practicing safe sex methods to prevent AIDS isn't worth the effort.	18-30	0	0	9.1	63.6	27.3
	31-45	0	11.1	11.1	33.3	44.4
	46+	0	20.0	20.0	60.0	0
	total	0	8.0	12.0	52.0	28.0
Disbelief Subscale						
Learning about AIDS is too complicated.	18-30	0	0	9.1	81.8	9.
	31-45	0	0	0	88.9	11.1
	46+	0	0	0	100.0	0
	total	0	0	4.0	88.0	8.0
Only sissies worry about getting AIDS.	18-30	0	0	18.2	72.7	9.1
	31-45	0	11.1	0	77.8	11.1
	46+	0	0	0	100.0	0
	total	0	4.0	8.0	80.0	8.0
I don't think I could get AIDS from someone in my own community.	18-30	9.1	27.3	0	54.5	9.1
	31-45	0	22.2	11.1	55.6	11.1
	46+	0	40.0	0	60.0	0
	total	4.0	28.0	4.0	56.0	8.0
AIDS is God's punishment for a person's sins.	18-30	0	9.1	9.1	45.5	36.3
	31-45	0	11.1	11.1	44.4	33.3
	46+	0	40.0	0	20.0	40.0
	total	0	16.0	8.0	40.0	36.0
Motivation for Education Subscale						
I would read a pamphlet about AIDS.	18-30	27.3	72.7	0	0	0
	31-45	0	100.0	0	0	0
	46+	0	100.0	0	0	0
	total	12.0	88.0	0	0	0
I would watch a TV program about AIDS.	18-30	18.2	81.8	0	0	0
	31-45	22.2	77.8	0	0	0
	46+	20.0	80.0	0	0	0
	total	20.0	80.0	0	0	0
I would go to an educational meeting about AIDS.	18-30	9.1	81.8	9.1	0	0
	31-45	11.1	88.9	0	0	0
	46+	0	100.0	0	0	0
	total	8.0	88.0	4.0	0	0
Lack of Action Subscale						
Since babies can get AIDS, education won't help.	18-30	0	0	18.2	54.5	27.3
	31-45	0	22.2	0	22.2	55.6
	46+	0	20.0	20.0	60.0	0
	total	0	12.0	12.0	44.0	32.0
Talking with a partner about preventing AIDS will destroy the romance.	18-30	0	9.1	9.1	81.8	0
	31-45	0	11.1	11.1	77.8	0
	46+	0	0	20.0	80.0	0
	total	0	8.0	12.0	80.0	0

CONTD	FEMALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Only people with many partners get AIDS.	18-30	0	9.1	27.3	54.5	9.1
	31-45	0	22.2	0	77.8	0
	46+	20.0	40.0	20.0	20.0	0
	total	4.0	20.0	16.0	56.0	4.0
Learning about AIDS won't make any difference whether I get AIDS or not.	18-30	0	9.1	0	63.6	27.
	31-45	0	22.2	0	77.8	0
	46+	0	20.0	0	80.0	0
	total	0	16.0	0	72.0	12.0
Safe Sex Item						
I would use safe sex methods to prevent the spread of AIDS.	18-30	18.2	63.6	18.2	0	0
	31-45	11.1	88.9	0	0	0
	46+	20.0	80.0	0	0	0
	total	16.0	76.0	8.0	0	0

Note. n's for females 18-30 years = 11; 31-45 years = 9; 46+ years =5 ; total = 25

FEAR of AIDS SCALE

Percent Response

Scale items	FEMALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
I wouldn't mind being in the same room with a friend who has AIDS.	18-30	9.1	63.6	27.3	0	0
	31-45	0	77.8	0	22.2	0
	46+	0	60.0	40.0	0	0
	total	4.0	68.0	20.0	8.0	0
(A centralized) One file containing names of all people known to have the AIDS virus should be kept.	18-30	9.1	54.5	9.1	27.3	0
	31-45	0	33.3	22.2	44.4	0
	46+	0	60.0	40.0	0	0
	total	4.0	48.0	20.0	28.0	0
If I found out a friend had AIDS, I would be afraid to hug him/her.	18-30	0	9.1	18.2	54.5	18.2
	31-45	0	11.1	22.2	66.7	0
	46+	0	20.0	20.0	20.0	0
	total	0	12.0	20.0	60.0	8.0
I would object to sending my child to a school which had a child who has AIDS.	18-30	0	9.1	36.4	36.4	18.2
	31-45	0	11.1	11.1	77.8	0
	46+	0	20.0	20.0	60.0	0
	total	0	12.0	24.0	56.0	8.0
I believe public officials when they say AIDS cannot be transmitted through casual contact.	18-30	9.1	72.7	9.1	0	9.1
	31-45	0	66.7	11.1	22.2	0
	46+	20.0	60.0	20.0	0	0
	total	8.0	68.0	12.0	8.0	4.0
I am afraid that I will get AIDS.	18-30	18.2	18.2	9.1	54.5	0
	31-45	0	22.2	0	77.8	0
	46+	0	20.0	0	80.0	0
	total	8.0	20.0	4.0	68.0	0

CONTD	FEMALE Age*	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
AIDS children should be allowed to attend public school.	18-30	9.1	54.5	27.3	9.1	0
	31-45	0	77.8	11.1	11.1	0
	46+	0	60.0	40.0	0	0
	total	4.0	64.0	24.0	8.0	0
Compared with other public health problems, I think AIDS as a very (minor) small problem.	18-30	0	0	0	72.7	27.3
	31-45	0	11.1	0	66.7	22.2
	46+	0	0	0	80.0	20.0
	total	0	4.0	0	72.0	24.0
If I found out that my lover had AIDS, I would still have sex with him/her.	18-30	0	0	36.4	36.4	27.3
	31-45	0	0	44.4	33.3	22.2
	46+	0	20.0	60.0	20.0	0
	total	0	4.0	32.0	40.0	24.0
The seriousness of AIDS is greatly overblown by the media.	18-30	0	18.2	18.2	45.5	18.2
	31-45	0	44.4	11.1	44.4	0
	46+	0	20.0	0	80.0	0
	total	0	28.0	12.0	52.0	8.0
AIDS will become a severe and widespread epidemic.	18-30	9.1	63.6	18.2	9.1	0
	31-45	22.2	44.4	11.1	22.2	0
	46+	20.0	60.0	20.0	0	0
	total	16.0	56.0	16.0	12.0	0
I am worried about catching AIDS in a public washroom.	18-30	0	27.3	0	54.5	18.2
	31-45	0	11.1	11.1	66.7	11.1
	46+	0	40.0	0	60.0	0
	total	0	24.0	4.0	60.0	12.0
Even if a friend had AIDS, I wouldn't mind touching him/her.	18-30	9.1	63.6	27.3	0	0
	31-45	0	77.8	11.1	11.1	0
	46+	0	80.0	20.0	0	0
	total	4.0	72.0	20.0	4.0	0
If I found out a friend or lover had AIDS I would be afraid to kiss him/her.	18-30	0	27.3	45.5	27.3	0
	31-45	0	33.3	11.1	55.6	0
	46+	0	60.0	20.0	20.0	0
	total	0	36.0	28.0	36.0	0

Note. n's for females 18-30 years = 11; 31-45 years = 9; 46+ years =5 ; total = 25

APPENDIX D

Correspondence related to Research

FACULTY OF HOME ECONOMICS

APPROVAL
for
PROPOSAL ON HUMAN RESEARCH

This is to certify that Lucy C. Judge

a student in the Department of Family Studies

presented a proposal for a research project entitled:

Identifying Aids Educational Needs of Metis Adults

and that the undersigned Committee are now satisfied that the ethical criteria for human research have been met.

Date: April 14, 1988

Marlene Cox-Bishop

Nancy L. Hurlbut

Doris L Badir

Signatures

Elizabeth Metis Settlement Association
Box 420, Grand Centre, Alberta T0A 1T0
Phone: 594-5026 or 28

July 4, 1988

LUCY JUDGE, GRADUATE STUDENT
DEPT. OF FAMILY STUDIES
801 GENERAL SERVICES BLDG.
UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA T6G 2H1

Dear Lucy;

We, the Elizabeth Settlement Council, approve of the study which you plan to do in our Settlement.

This is a "Right of Entry" letter for you to proceed with your plans. Thank you.

Yours truly,

Lee Desjardais
Madeline Cardinal

ELIZABETH SETTLEMENT COUNCIL
ELIZABETH METIS SETTLEMENT

/ml

"OUR LAND — OUR CULTURE — OUR FUTURE"

DEPARTMENT OF PSYCHOLOGY
THE UNIVERSITY OF TEXAS AT AUSTIN

Mezes Hall 330 · Austin, Texas 78712

October 27, 1988

Ms. Lucy Judge
Department of Family Studies
Faculty of Home Economics
3-38 Assiniboia Hall
University of Alberta
Edmonton
CANADA T6G 2H1

Dear Ms. Judge:

You have my consent to use the "Fear of AIDS" scale in any research you care to do.

I enclose the 1987 form of the questionnaire we used. This is identical to the 1985 form except that Items 36 and 37 have been added and two control Items from the Change Scale have been deleted.

In addition, I have also enclosed a copy of our manuscript which is in press in the *Journal of Applied Social Psychology*.

Good luck in your research.

Sincerely,

Robert K. Young
Professor

EBH

SUITE 500, 10216 - 124 STREET
EDMONTON, ALBERTA T5N 4A3
TELEPHONE (403) 482-1965

1988 12 07

L. Judge
Department of Family Studies
Faculty of Home Economics
3 - 38 Assiniboia Hall
University of Alberta
Edmonton, AB
T6G 2H1

Dear Ms. Judge:

You have requested permission to use the AIDS Questionnaire (docket #87085) in the report "Perceptions and Attitudes Towards AIDS and AIDS Prevention Among Youths and Parents". As this report has been published and as there is no copyright on this questionnaire, you certainly may use it.

This questionnaire was designed by the Results Group and some of the health professionals on the Edmonton Interagency Council on AIDS did not feel it was a very good assessment tool. It was not tested for face and content validity and the assessment of knowledge, via the questions, ranges from a very simple to quite a complex understanding of AIDS.

With these limitations in mind, hopefully you can use it more appropriately.

Sincerely,

M. Luger

per Ellie Robson
Health Promotion Consultant
Health Promotion Division

ER:sm

British Columbia Health

Division of S.T.D. Control
828 West 10th Avenue
Vancouver
British Columbia
Phone: (604) 660-6170

Province of British Columbia Ministry of Health
PREVENTIVE SERVICES

Sandra Chan
Research Officer — AIDS
B.C. Centre for Disease Control

828 West 10th Avenue
Vancouver
British Columbia
V5Z 1L8

Phone (604) 660-6173

Ministry of Health
Sandra Chan, RO3
Room 204 - 828 West 10th Ave.
Vancouver, B. C.
V5Z 1L8

July 19, 1988

Lucy Judge
211 Mohr Avenue
Spruce Grove, Alberta
T7X 2J5

Dear Lucy,

RE: VIDEOTAPE "Aids - The New Epidemic"

Part of our mandate involves the dissemination of AIDS resource material in a manner which would be easily accessible to the public. Consequently, we actively encourage individuals to freely make copies of our videotape. I am pleased to hear that you are impressed with our videotape and give you permission to use it in your study.

We are presently trying to accumulate resource materials designed for both native Indians and Metis. If you are aware of any appropriate posters, pamphlets, or audiovisual tapes which were developed specifically for Canada's aboriginal peoples, I would appreciate it if you could let me know. Your own work in identifying the AIDS educational needs of Metis adults sounds very interesting and a worthwhile endeavor. I would appreciate being kept up-to-date with your findings as we are considering producing an AIDS videotape for native Indians in the very near future and the recommendations drawn from your study would help us considerably in our effort.

Due to the time constraints we are presently operating under, I would appreciate receiving any information or suggestions you may presently have, despite the fact that drawing conclusions may still be a little premature, as having some direction in identifying the AIDS educational needs of aboriginal peoples is better than no direction.

Thank-you for all your help! Should you ever require any further assistance from B.C.'s AIDS Project, please do not hesitate to give me a call.

Yours sincerely,

Sandra Chan